CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Guysborough, Nova Scotia

DATE HEARD: February 24, 2020

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EXHIBIT LIST

February 24, 2020

COURT OPENED (09:48 HRS)

THE COURT: Mr. Russell.

MR. RUSSELL: Yes, Your Honour. The Inquiry counsel will proceed with calling the evidence of Dr. Paul Smith.

THE COURT: Good morning, Dr. Smith.

A. Good morning.

DR. PAUL ASHLEY STAR SMITH, sworn, testified:

THE COURT: Dr. Smith, during the course of the morning you're likely to be shown some documents. The documents will come up on the monitor in front of you. There will also be a hard copy of the various documents in the binders in front of you. I think most of the documents presently are in Volume 3. There's a water pitcher in front of you, serve yourself if you like, and if you would like a break before I call for a break, just let me know and we'll find an opportunity to pause. Thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Dr. Smith.

A. Good morning.

Q. Thank you for coming today. The one thing I would just indicate that the sound will be picked up but if you could kind of be mindful to speak up, you know, so all of us can hear.

A. Yes.

THE COURT: Maybe ...

A. I am hearing impaired. Sometimes I hear it better

than what it seems to project as so if I ...

THE COURT: So maybe what we'll do is we'll move Dr. Smith's microphone just a little closer to him, move that volume out of the way. There we go. It all goes to those cords on the floor that seem to get in the way of the rollers of that chair as well, Dr. Smith, but feel free to roll right over them if you like, you won't hurt them. Thank you.

MR. RUSSELL: Doctor, if anything this morning, if I sound too low or something's unclear, let me know, I can re-ask ...

A. Thank you.

Q. ... and we can direct it that way. So, Doctor, could you state your full name?

A. Dr. Paul Ashley Star Smith.

Q. And Dr. Smith, what is your occupation?

A. A medical doc, family physician.

Q. And how many years have you been a physician?

A. Forty-two years.

Q. That's a long time.

A. Yeah.

Q. And 42 years, has it always been in family practice?

A. Yes.

Q. We're going to get into the particulars of your

current practice and how it's structured in a little bit but your family practice, I guess, where is that based out of?

A. I work in outlying areas, I work in McAdam and Fredericton at this time and I have an office also in Harvey.

Q. So you also have an office in Harvey so McAdam, Harvey and Fredericton, being from Nova Scotia, I guess geographically how close or how far away are they?

A. Within 70 kilometers of one another.

Q. Do you have more than one office? You said you had an office in Harvey?

A. My main office is in Harvey. I have a satellite office in Fredericton and I work as a rural physician at a health care center in McAdam.

Q. In your office are you the only physician in your current practice?

A. Yes.

Q. Have you spent most of your career as a solo practitioner?

A. Yes.

Q. We're going to look at an exhibit, it's going to be in the second binder and it's also going to be on the screen, exhibit number 91.

EXHIBIT P-000091 - *CURRICULUM VITAE* - DR. PAUL A.S. SMITH

A. Okay.

Q. If we could zoom in a little bit and scroll down. So, Doctor, this is your *CV*, it's something you're familiar with?

A. Yes.

Q. We're going to take you through your *CV*, I think it's important as a doctor 40-some years to see the nature of your practice and your training and experience. So you would have gotten your medical degree when?

A. 1978.

Q. And from where?

A. From Dalhousie University in Halifax.

Q. Below that there's a CCFP 2009 active, what is that?

A. Canadian College of Family Physicians, it's an additional certificate after further training and activity and examination to upgrade your original degree. So it's a family physician designation.

Q. I note as well that there's a number of additional certificates and training that you've kind of taken over the years.

A. Yes.

Q. I'm just going through some of those very briefly.

Some of them are very self-explanatory but others may need further elaboration. ACLS and ATLS, what's that?

A. ACLS is acute cardiac life support and ATLS is acute trauma life support.

Q. You have training in it says acupuncture, hypnosis, nutritional analysis, environmental medicine, family dynamics, short-term dynamic therapy. What is, I guess we'll start with hypnosis, is this part of your current practice?

A. Yes and no. The training, *per se*, I was quite interested in the communication aspects of what hypnosis was all about and why it worked and things like that so I don't use hypnosis, *per se*, I've incorporated what I've learned into my communication with patients and so on and so it would be part of my understanding of how communication works.

Q. So, Doctor, currently in your practice is hypnosis part of your practice today?

A. Not in a pure sense of hypnosis, I just incorporate it into my understanding of how communication works.

Q. Okay. Environmental medicine, what is that?

A. It's just a study of how toxins and environment impact on some people's lives and I did a clinical trainee shift with Dr. Fox in Fall River in Nova Scotia here and separate training

and courses otherwise just to understand the environmental aspects. I had people that had multiple chemical sensitivity and things like that, I was just trying to make an understanding for myself more than anything else.

Q. Family dynamics, what is that training?

A. Family dynamics is how the past and the present and transference works. Transference is how their past experiences affect the current relationships that they have and so on so, again, it's just a way to understand how family dynamics basically are impacted by their past experience and current experience.

Q. Short-term dynamic therapy, what is that?

A. That's basically the same idea, it has to do with family therapy and how to communicate with a couple or counseling and so on, along those lines.

Q. Sort of like a spousal situation, husband and wife?

A. Yes.

Q. In terms of training, there's CBT or referred to as cognitive behavioural therapy, what's that and what sort of training do you have in that?

(09:57:59)

A. The Canadian Association of Cognitive Behavioural

Therapy has some excellent modules that they use to train family physicians again in communication and how you can impact the way people think about any aspect of their medical career or medical life I should say. It's a way to impact the way they understand, perhaps they are caught into thinking traps or ways that they may have collective abnormal thinking about certain aspects so it's just a way to analyze and to impact a new point of view, really, that might be healthier.

Q. And so perhaps explain to me. My understanding, it appears that sort of clinical therapist, psychologist or mental health nurse would sort of actively use cognitive behavioural therapy with a patient?

A. Correct.

Q. In your current practice do you use some of those aspects in your treatment of patients?

A. Absolutely, yeah.

Q. And treatments of patients specifically with mental health issues?

A. Mental health and any other aspects. Their belief systems impact the way they ... the way their health results so, you know, if you can impact the way they feel or their thinking about things, you've been able to change the reality for that

patient.

Q. So generally, I'm just going to hit some of the highlights of your history of your practice which you said was mostly or primarily in family medicine over the 40 years. You were president of the medical staff, it says QNHC, from '97 to '98, what was that role?

A. Queens North Health Center is just one of the ... it's in Minto and we had a group of physicians where basically I was just the head of that group, you know, as president. I represented ... when we had meetings, I was in charge of presenting facts or the topics for the day and controlling the meetings and so on.

Q. And years later it looks as though you became president again of medical staff, Chipman, New Brunswick between '97 and '98?

A. Yes.

Q. Was that a similar role, I guess, but with a different group of doctors?

A. Yes.

Q. Further down it indicates that you were medical advisor for a nursing home?

A. Yes.

Q. What were your duties there?

A. I was in charge of seeing the patients but also helping policy changes and decision-making and just as topics come up to help them advise which direction we go with things.

Q. What seems sort of, I guess, most relevant to today in my mind anyway, from 2000 to 2001 it indicates you did some contract work for DND, is that Department of Natural Defence?

A. Yes.

Q. National Defence. And it indicates ER room physician, Gagetown.

A. Yes.

Q. If you could tell us a little bit about your experience between 2000-2001 with the contract work for DND and the physician in Gagetown ... ER physician.

A. I was hired on a contract, I didn't sign into the military, I was just hired as a contract to work at their medical unit in Gagetown doing basically family medicine again. I worked there for the year to see any medical issues that came up and to help direct therapies and so on in any direction.

Q. So I take it where it was contract work for National Defence ...

A. Yes.

Q. ... you would have had experience dealing with members of the military, retired veterans, those sort of clients?

A. Not retired veterans, they were serving.

Q. They were serving veterans?

A. Yes.

Q. During that period of time are you able to sort of estimate how many veterans, I know it's a long time ago and I understand that it's hard to put a number, but could you estimate roughly how many military members you might have treated over that period of time?

A. Well, we worked five days a week and we'd see 20, 30, 40 depending on the demand that day, it was pretty busy.

Q. And would that involve complaints as it relates to both physiological concerns and mental health concerns?

A. Yeah, everything family medicine incorporates, yeah.

Q. What about sort of military officers who had been dealing with psychological disorders such as post-traumatic stress disorder, major depressive disorder, would you see those sort of things?

A. Yes.

Q. And from that period on we understand that you were in solo practice in family medicine since 2001?

A. Yes.

Q. It indicates as well from 2007 to present you're the director of the methadone program in McAdam?

A. Yes.

Q. And what does that involve?

A. It's just again setting up policies and treating people that had narcotic addiction issues and so on and directing the program for that. It's a fairly small unit but we'd see some of these smaller towns had quite significant problems with addiction issues as usual so we were in charge of looking after most of those patients.

Q. Was there any sort of special training or experience required to be the director of the methadone program?

A. Yes, there's specified courses that are required to become designated for that.

Q. And I understand you have noted on your *CV*, the second page, that you were an expert witness, nine occasions, in courts in New Brunswick?

A. Yes.

Q. Generally, without getting into the actual nine or the details, what sort of expert evidence were you involved in giving?

A. It would be family medicine topics, anything from family disputes to someone with dizziness or giving opinions on whether there was malpractice perhaps and things like that. I was designated by one of the law firms in Fredericton to be a useful witness in some of their participants and so on. So we would give opinions and occasionally called to court for that opinion.

Q. Were you ever in a position where you gave expert evidence as it relates to medical treatment, cannabis, and psychological disorders?

A. Cannabis was never a topic, no.

Q. And I understand you indicated you participated to some degree in three medical pharmaceutical research projects?

A. Yes.

Q. What were those?

A. It was research. Blood pressure and antibiotic side-effect profiles, and effectiveness profiles and things like that so just you would have "x" number of patients involved with the use of their new medication. You'd be monitoring for side effects and reporting that through the central collection of information.

Q. And I don't mean to get into the details at this

point, we will at some point later, if we could bring up Exhibit 141.

EXHIBIT P-000141 - STUDY - "MEDICAL CANNABIS USE IN MILITARY AND POLICE VETERANS DIAGNOSED WITH POST-TRAUMATIC STRESS DISORDER"

Q. Doctor, do you recognize what this document is?

A. Yes.

Q. What is that?

A. Well, that's a study that we started in, I think, 2015 to monitor ... we did a retrospective study in terms of picking random patients and monitoring their response to the treatments that we offered in terms of medical marijuana use.

Q. So this particular study, is it fair to say it looked into medical cannabis use as it relates to military and police veterans diagnosed with PTSD?

A. Yes.

Q. And the study took place, did you say, 2000-?

A. I think it was '15 to '16, I believe.

Q. And it was published when?

A. In '17 or late '16.

Q. Typically research, or medical research such as this and studies, who would have sponsored this particular study?

(10:07:48)

A. This is a study we did on our own to make sure that we were ... it was new in the industry so our College actually recommended that we do some kind of study and monitoring to see what we were doing, was it useful, and to publish something that would indicate our activities and so on. So it really was we started collecting just my clinical notes over that time period to see the response but it was retrospective to it didn't meet the standards of peer review, what do they call it, double-blind studies and so on, it was just a retrospective study.

Q. So often we have studies that may be sort of sponsored by different medical insurance companies or drug companies.

A. Yes.

Q. Was this study sponsored by any of those?

A. The only sponsoring was you'll notice the other people on the list after my name there were people that were experts in data analysis. The cost of their participation was sponsored by one of the licensed producers, MedReleaf, because you know, they knew that we were using their products and I think they thought that was a good way for advertising and so on.

Q. And so MedReleaf was one of the providers of medical cannabis?

A. Yes.

Q. I guess, and now is the time I guess, as good as any, I guess. We'll get into what was, if you can, without getting into everything, p-values, the whole works, but what was the general purpose of the study and what were the ultimate results that you had found at the end of the day with respect to this study?

A. I can't get into analysis of p-values and so on because that's not my expertise but the general gist of this study was simply to indicate before and after use of medical marijuana, using the ten criteria that we used for the diagnosis of PTSD, and on a scale of ten, ten being the worst and zero being no symptoms, we monitored the response over a period of time in terms of improvement of people just on medical marijuana. They may also have been on medications and other therapies at the same time so we didn't differentiate or separate the groups, we just did a general retrospective analysis of ...

Q. And how many participants ... I believe there was 100 veterans?

A. A hundred, yes.

Q. Participated in the study and ultimately what was sort of the conclusion that was found and realizing that this is just

one study but what was the end result?

A. Well, we found it was very effective in symptom relief. I mean, our numbers are probably in the 50 to 60 percent range improvement and that there was some people that were able to come successfully off of medications during that time if they chose, under supervision, of course. And I think the study speaks for itself in terms of the aspects of reduction of suicide which was our initial goal for the study to begin with.

Q. So ...

A. Sorry. And quality of life, that was the other big aspect and so a reduction of alcohol use and things like that too.

Q. Okay. And in the "Conclusion", we see down at the bottom and I'll read it, it says: "Future studies should consider involving larger sample sizes and controls to determine the efficiency of medical cannabis in reducing PTSD-related symptoms both as a first line and alternative treatment option." So were there concerns with respect to the sample size perhaps being overly small and there's room for further assessment?

A. Yes. I mean a hundred's reasonable for a study but I mean it'd be nice to have 1,000 or 10,000 of course. You know,

bigger studies would always give better information and I was the only center probably because I think I was one of the few docs interested in the topic at the time so, you know, there was only one center being used as a source of information, too, clearly that was a weakness in the study, of course.

Q. In Canada in particular, is it fair to say that cannabis use, as a form of medical treatment as it relates to psychological disorders or symptoms is a relatively newer concept?

A. Yes, it's very new and there are very few studies. At this point, it may have been one of the initial studies done in Canada. There's several others, lots of research going on. We're also involved in preparing to do other studies ourselves but there's many more studies on the go now that things are legalized and more acceptable.

Q. So is it fair to say, and I certainly don't want to put words in your mouth so elaborate or correct me, but is it fair to say we're still really early days when it comes to evaluating the effectiveness of cannabis treatment for psychological issues?

A. Yes.

Q. Yes?

A. Yes.

Q. And is it fair to say that there isn't a whole lot of sort of peer-reviewed research in the medical community as it relates to PTSD, military, and cannabis treatment for those underlying psychiatric or psychological disorders?

A. Yes. I mean growing numbers. I think other countries have certainly evidence and we tend not to look at outside our own country for evidence, mind you, because you know, the Americans and Europeans have certainly done some excellent studies I thought that were in the same direction of this one but in Canada things are slow. We've only been legal for a couple years here now so things are just in the beginning stages of knowing how effective it can be if done correctly.

Q. Okay. If we look to page two of Exhibit 91 which is your *CV*, and we're moving to sort of present day in your particular practice. You note here, it says you have specialized practice in assessment and utilization of medical marijuana, 2014 to present. What is that specialized practice?

A. Well, we are looking at an understanding of how you use medical marijuana in a very specific way, specific strains and doses, to be safer and more effective. So I think we've looked at what worked and what didn't work, we've learned from

all our mistakes, and moving towards a point where we are able to recommend and reproduce more effective ways of doing things.

Q. In terms of the breakdown of your present practice and I realize numbers can fluctuate, approximately how many patients, both for physiological symptoms and psychological symptoms, that you may treat in the run of a year?

A. How many patients do I have?

Q. Yeah.

A. Ongoing? Somewhere between 1,500 and 2,000, in that range.

Q. And out of the 1,500 to 2,000, realizing it's hard to put an exact percentage, what percentage of those would you say were affiliated with the military either presently in active service, retired service, or military veterans? So out of the 1,500 to 2,000, what percentage of your practice would deal with military affiliation patients?

A. I would estimate probably 75 percent, the others would be RCMP and first responders.

Q. So your practice sort of is a particular subset, I guess, of individuals of the population, is that fair to say?

A. Yes.

Q. And we'll get into how that developed momentarily.

And a focus of your practice involves cannabis as a form of treatment?

A. Yes.

Q. And it involves cannabis as a form of treatment for both physical ... physiological symptoms and psychological symptoms?

A. Yes.

Q. Are you able to estimate what percentage of your ongoing patients, between 1,500 and 2,000, are on medical prescribed cannabis?

A. There would be probably in the 85-90 percent range. There's some that just don't do well with it and that's fine, we're not here to, you know, just look after the patients that do well. The pain aspect is a big deal. There would be, I would say, 80, 90 percent of people have severe pain and would like alternatives to narcotics or other pain therapies and so on or an additional treatment while they're receiving other forms of therapy as well.

(10:18:16)

Q. If you were to put a percentage of patients, the category of patients that you have that are affiliated with the military in some form, what percentage of those would you say

are prescribed medical cannabis?

A. I'm not sure I understand your question there.

Q. Okay. So we know 1,500 to 2,000 patients.

A. Yes.

Q. I think you indicated approximately was it 85 percent are affiliated with military?

A. Yeah, 75.

Q. Seventy-five, sorry. So out of that 75 percent of patients, how many of those are prescribed medical cannabis for treatment?

A. Most would have a trial of. End up with marijuana, probably in the 85, 90 percent.

Q. Okay. When you look at your practice as it is currently, are you able to sort of estimate how many of your patients involve simply physiological symptoms or complaints versus psychological only complaints versus a combination of both?

A. The combination is majority. Pain causes psychological issues. Psychological issues on their own would be actually rare. Most military and RCMP have many physical complaints and the pain obviously impacts their psychological health, as well. so the combination is the vast majority.

Q. So your current practice, as indicated, seems to be a very subset, almost like a speciality in a sense. How did your practice develop, what sort of led you to the point where you have the current setup of your practice?

A. Well, I've prescribed medical marijuana for pain as far back probably as 2004 or '05. That's how it began. In terms of my significant involvement, in 2014, you know, I was at a place where there were several suicides that year, a few of the guys I knew quite well, and my question simply was, you know, What are we doing for the guys? And the answer from the vets was
simply if the pills didn't work, they were, basically, on their own. So on their own they were finding that marijuana that they could fine, typically off the street at that point, was their best alternative to calm the symptoms of PTSD or help the pain and things like that. So I became interested in the suicide aspects of this because of the group where medication or standard therapy, which would involve psychotherapy and pills, seemed to fail this group and there seemed to be a fair, large group in that category. So I became interested in the fact that this could be an alternative.

I spoke to the College about this and they were cautiously

optimistic and said, Yes, if you do this correctly and you do it in a way that we can see what's going on; thus, they recommended the study as soon as possible, that we would proceed and see if this was a viable alternative or not.

Q. And when you spoke about the suicides, I take it you're referring to suicides of veterans?

A. Yes.

Q. And when you were talking about this concept of evaluating and the treatment of suicides in patients, again you're talking about veterans?

A. Initially, yes, yeah. The RCMP and first responders evolved into the process. You know, as they started to hear that, Oh, there is an alternative to medications, which many people did not do well with or did not appreciate because of side effects, that they started to, you know, knock on the door to see if they were a candidate, you know, to do a trial therapy, at least, and see if it was something they could incorporate into their lives.

Q. In terms of, and I should explain, when I use the term "veterans" would it also include members that are in active service or temporarily out of service, they're still ...

A. Typically out of service, yes; I mean after they've

been released, yes.

Q. And so prior to the shift in focus, I take it you probably had a fairly busy demanding general family practice?

A. Yeah, I was working rural medicine for probably 30 years, by that time, seeing 30 and 40 people a day, and I was getting older and, you know, it was starting to wear me down a little bit. So I was more than interested in spending more time with people where I could actually slow down the number of people I was seeing per day and talk to them more. I don't appreciate necessarily at this stage of my life doing the 40 people, you know, 40 people a day. I don't think that's effective medicine, either, but that's the way the system is set up at this point. I like to spend a little more time with people and get to know them and do it that way.

Q. Are you able to estimate how many patients you may see a day? You have a pretty big patient base, 1,500 to 2,000. Are you able to say how many you see a day now?

A. At this point I try to keep it down to between eight and 12 per day. Some are quick and fast; most of them I spend an hour with or more. So an initial patient might be an hour and a half to two hours, to get to know them, originally, and then follow-ups are easier and quicker once you know them

better.

Q. And so at times how quick can a follow-up appointment for, say, someone that you met with on a first occasion, they have a pre-existing diagnosis for, we'll just use PTSD, for example, you've determined they're a suitable candidate for cannabis-based treatment, I know it can range, but how quick can some of the follow-up appointments be?

A. 45 minutes to an hour.

Q. In terms of the development of how you get to where you are today, and we'll get into your sort of structure that you have, I understand that you were affiliated at some point around 2014 with a group called Marijuana For Trauma.

A. Yes.

Q. What is that group Marijuana For Trauma? I'm assuming it still operates?

A. I think it may have been dissolved at this point and redefined or broken off or split into different groups but originally it was a group of veterans that had a very similar dream. They obviously had discovered marijuana for their own use, typically off the street, initially, and they had found it very effective and they were advocates for telling the world that marijuana works for many things. That was their goal. But

our unified goal was simply to develop programs and centers where veterans could go and have a sense of identity and meet their buddies and feel as though they were part of something again. Because, you know, one of the biggest problems when people get out of the Canadian Forces is that they have lost their identity as a member of anything. The Armed Forces may have been one of the only things that they've actually identified with and now, out, they feel lost and can't work and many times families are falling apart, and we were just trying to offer a center where people could get together and talk and become part of something again.

Q. So when were you, as a physician, when were you connected with that group Marijuana For Trauma, around what years, do you recall?

A. It was after 2014, in that range, yeah.

Q. Do you recall, roughly, how long it sort of lasted?

A. I think it lasted for about a year and a half, until we finally hit a place where my philosophy was different enough from theirs that I thought it wise to, you know, go our own separate directions at that point.

Q. So what was it about the difference in philosophy that you had compared to what this group had when you decided to part

ways?

(10:27:51)

A. Well, we were finding that smaller doses combined with CBD and THC together were much more effective and actually our direction was more towards non-smoking altogether. You know, that was the evolution of things. Their philosophy was more towards, you know, bigger doses, smoke as much as you need to get the effects you're looking for - if it's not better, then smoke more. And I didn't appreciate that. I thought that smaller doses combined with CBD were much more effective and moving away totally from smoke to oil or edible versions of therapy. So we were using them as coaches, I think we'll probably get into that, and so because they were giving a different way of doing things than what I was trying to teach, I thought that was our basic breaking point.

Q. So when, are you able to roughly estimate as to when you sort of make the break from that group and kind of go towards your own structure?

A. I think it was by the end of 2015.

Q. And we know that, and we're going to get into the details, we know Lionel Desmond had been a patient of yours.

A. Yes.

Q. Had he been a patient of yours under the existing structure of sort of you, alone, or was he back at a time when you were affiliated with Marijuana For Trauma?

A. We were in the final stages of still with Marijuana for Trauma at that point, yeah.

Q. I'm going to ask you a little bit about the coaching structure as it was at that time with Marijuana For Trauma. What was a coach and what was the purpose?

A. The coach was a teacher of how to use medical marijuana. There's so many strains and variations and ways of doing things. We were trying to narrow down from just "here's a bag of marijuana, good luck" to, "no, I think we've learned some things", we would like to pass that on to people and teach them how to do it in a more effective way. That was the general ... So when someone had a question, it had to go, for a technical use of marijuana, the coaches were responsible for that. Anything medical would come back to me. So the idea of a coach helping people learn how to use marijuana correctly, connect with licensed producers and all the paperwork that that involves, which is quite extensive, that was the coach's job.

Q. What were ... Approximately how many coaches were around at that time that you were aware of?

A. I think on an average there was between six and 10 would be an average.

Q. What would their backgrounds be? What would a coach's ... Would they have any sort of medical background of any type or ...

A. No. Initially, they were basically veterans that were just helping veterans to be there if there was issues. They would not have medical training or anything like that. That was my oversee job.

Q. But they would have sort of routine contact with the patient?

A. Yes.

Q. Were they sort of compensated in any form to act as a coach?

A. They may have had some benefits to the licensed producers they used but other than that ... It was a lot of volunteer work, for sure.

Q. And do you know if they got benefits from... When you say licensed producers, those are the ones that provide the cannabis?

A. Yes.

Q. When you say they might have gotten benefits, do you

know if they did?

A. Well, it was standard that some of the licensed producers, not all, would give a benefit for the education of a patient to, you know, participate in the marijuana usage and so on.

Q. And the benefit, would it be financial compensation or cannabis or a combination of both, do you know?

A. I think more financial, probably. Yeah.

Q. Not to make myself as a witness, but I recall you indicated that the group might have been more interested in profits and you had taken a concern with that, I believe?

A. Yeah, I think as things went on they were giving more emphasis to the profit end of things but, I mean, they did require some funding to operate, of course, so that was ... But, you know, there's a balance that I thought might have been tipped in the direction of thinking more about profits instead of what they were there to do, which was teach a patient and make sure they were stable and be there for their questions and so on.

Q. At this point, Doctor, I'm going to turn to a little bit about cannabis, just to get into some details with respect to that. Is it a fair comment to say cannabis as a drug is

fairly complex?

A. Very.

Q. And what do we mean or what do you mean with agreeing that it's a complex drug? How is it complex? What makes it so complex?

A. Well, any one strain would have up to 140-plus components. The two major components that we make decisions from is CBD and THC still - even though there's many other well-known components that are minor and less likely to make decisions from, but, you know, they're getting more prominent - so any one strain would have that.

There's sativas which are meant during the day, they're typically, initially, THC, and indica is at night, which are more for sleep and pain, and then when they combine the two, they all become hybrids, which are combinations genetically of those two initial strains, and so there'd be variations on a spectrum between pure sativas to pure indicas and then with varying amounts of CBD, so very complex.

Q. So we're going to get into sort of the nature of the complexities and, I guess, first if we can start with what is ... So cannabis would contain THC and CBD?

A. Yes.

Q. What is THC and what is CBD?

A. THC is the component that would have psycho-active effects, impairment and addiction and, if overused, could have some side effects, if the doses were too high, and somewhat useful for pain. Now the CBD is the component that was known to be the major component for pain, no psychological impairment in the vast majority, and no addiction, and very good for controlling any of the psychiatric side effects that THC had, so ...

Q. And I understand that cannabis sort of ... can it act as both sort of a stimulant and, say, a depressant, or could have stimulating effects and depressant effects?

A. THC in excess is the most unstable aspect of marijuana. Too much THC has significant side effects - anger, agitation, anxiety, paranoia - and if you have a genetic tendency, you can have schizophrenia, bipolar exacerbations and so on, THC only. Does that answer that question?

Q. Yes. I have a few more questions regarding it.

A. Yes.

Q. In terms of cannabis as a drug, we know sort of certain antidepressants fit neatly in a category.

A. Yes.

Q. Does cannabis really fit in any category or is it it's own sort of thing out here?

A. I mean the word cannabis incorporates that whole spectrum of what we just talked about. There's very specific strains with some of these sub-chemicals, so to speak, the terpenes and flavonoids, which are well known to help depression, anxiety and things like that, as well as the CBD aspects and so on. So certain strains would be known to be very useful for anxiety and depression, to answer that question, in small doses.

Q. So before I get into the details of the strains, when you're prescribing cannabis for, in a treatment context, for psychological symptoms or disorder, what is the role THC plays in that in terms of a medical treatment aspect; for example, post- traumatic stress disorder and depression, we'll use those two. So you have a patient with PTSD and depression - what role does THC play in the treatment of that underlying psychological disorder?

(10:38:08)

A. The first thing, you know, that's real obvious with THC is that indicas are excellent for sleep and pain, which was, fit the bill quite nicely in most of these people, sleep being

an extremely important aspect of stabilization and recovery. CBD is known as probably the most Zen aspect of marijuana. It makes you comfortable right here and right now, you don't really care about the past or the future, so you can forget about your past traumas very effectively, if done at a reasonable dose. So it makes people able to get on with their day without being intruded with all the memories from the past, you know, such as PTSD, as well as control pain at the same time. So THC is a useful component, again in small doses.

Q. In terms of, back to the concept of strains, so in medical treatment in your practice, using cannabis as a form of treatment for psychological disorders and symptoms, how many different strains are available to a patient through you by way of prescription?

A. Thousands.

Q. Thousands.

A. And each licensed producer, of which there's probably over a hundred now, would have, you know, 10, 15, 20, some of the big companies even more, strain choices and so on.

Q. So in terms of ... in your practice do you deal with certain suppliers?

A. We work with the companies that the veterans would

choose.

Q. Okay.

A. So their having tried probably most of the licensed producers in Canada, vets will say, you know, There's my top five and there's my top one or two. So based on the effectiveness and availability of their strains ...

Q. So as a general rule, even though there are thousands, you typically see how many sort of strains being prescribed in the therapy?

A. Well, we're trying to narrow things down so we can give people what we know. There's so many different strains from different companies, you tend to use the companies that are well-liked and get to know their strains very well so we know what each strain would do. So any one patient would probably deal with two or three, maybe four strains, and that's it.

Q. If there's thousands of strains out there that could be prescribed, and you indicated that some act a little differently than others, naturally, because they're different strains, how did you educate yourself as to which ones to prescribe for a particular patient? How do you know?

A. It was learning from the patients that tried things, basically, and again following the rule that sativa's day,

indica's night, CBD is there for safety, and following those rules you can really narrow things down pretty fast. And any one company would have those particular choices and you'd get to know the strains from those particular companies pretty quick.

Q. And I understand, we'll talk THC and cannabis, and is it fair to say it has an element of instability to it?

A. In excess dose, yes.

Q. And what sort of, in excess dose what sort of instability ... what is instability of THC in an excess dose?

A. Again, the effective dose of THC is what ... It's extremely small. Once you exceed the ability to or the person's tolerance to THC at any given time, you're now in excessive dose. So we typically start so low they feel nothing and slowly work their way up within their tolerance, which takes a few days to develop, until they reach a therapeutic level. So, again, to answer your question, the instability of THC comes from too much too fast or doses that are too high, which can cause anger, agitation, anxiety, paranoia, and schizophrenia and bipolar in those specific rare ... more rare groups but those things are THC excess symptoms.

THE COURT: I have a question.

A. Sure.

THE COURT: So the relationship between THC, CBD, and the relationship between the quantity of THC for any given CBD uptake, how do you work that out?

A. We, typically ... At this point it's evolved so that there's no such thing as THC by itself.

THE COURT: Mm-hmm.

A. CBD is always there for safety because it prevents the memory loss, much of the addiction, and dramatically reduces the impairment based on the ratio between the two, and also CBD has been shown increasingly to be very effective for the psychiatric aspects of THC side effects.

THE COURT: And if you advise somebody that they should be on CBD, whatever the quantity is and however often they take it, is there, along with the CBD, is there some THC that is part of that preparation, if I can put it that way?

A. You can use CBD alone, there's no impairment. That would be the person with pain. It's not too bad for anxiety and depression, but the THC becomes an important part of the psychiatric part of that treatment. Our definition of what we use at this point is CBD and THC as an oil, never THC alone, at any point, in any one day. Every day would include some CBD combined with THC, typically, as an edible or an oil, because

it's reproducible, and the smoking of THC is unpredictable and vastly, the chances of overdosing with smoke is much higher than with an edible, right, you can measure in drops or mils or dropperfuls or things like that. So it's ... the evolution of what we call medical marijuana is now CBD and THC together as an edible. So people don't go out the door anymore without being told that that's what medical marijuana is - if you decide to smoke a little bit here and there, you have to be careful with the side effects and this is what you're looking to potentially get into if you do that. Unfortunately, that's the definition of recreational marijuana is you smoke THC and/or CBD perhaps, which is not, I'm not in favour of the current use of marijuana the way it is for recreational marijuana because of the safety aspects of that.

THE COURT: Thank you.

MR. RUSSELL: So, Doctor, I want to go into, back to sort of the elements of instability and THC, and you alluded to the fact that somebody might have a pre-existing and may not even be aware, say, of bipolar disorder or schizophrenia ...

A. Right.

Q. And are there some inherent risks that prescription cannabis could compound or make those symptoms show or worse?

A. Yes, when, especially if you smoke THC alone, because you can't control the dose and you get excessive amounts of THC, which is the place where those side effects are most likely to exacerbate schizophrenia, bipolar, or just even people without those two things would have side effects if they had too much THC.

Q. So what about somebody that is coming to a doctor such as you for cannabis treatment as it relates to anxiety, depression? Can smoking cannabis as the method of sort of treatment, can it, in fact, make those symptoms worse?

A. Yes, if done incorrectly, correct.

Q. And what are sort of scenarios where it can make the very symptoms that they're trying to treat, by smoking it can make them worse, what are the sort of scenarios where that can happen?

A. If they decide to smoke where they can't control the dose, they're going to have excessive THC, if they haven't combined the CBD, which is much more stabilizing. So, basically, if they smoke too much THC they would have potential side effects.

(10:47:50)

Q. In terms of sort of an overall, and I realize that

many psychological disorders have various subsets of components to them, and what I mean is sort of depression can have a number of symptoms with it, for example, repeated thoughts of ... Well, we'll use Lionel Desmond, for example. There was indications from the psychiatrist Dr. Slayter that he had sort of broad or recurring thoughts of jealousy towards his wife. Is there a system in that cannabis taken in the wrong dosage, too high of a dose, could make those symptoms worse, those repeated thoughts?

A. The potential of too much THC causing some paranoia is a real issue. The nice thing about smoking something is that it only lasts three hours. If someone has persistent paranoia it probably is not from that, it could have just been an underlying paranoia that the person has already unless the person smokes all the time, in which case that could be an issue.

Q. And is it fair to say that, I guess, cannabis treatment in the form of whether it's smoking or, as you say, in terms of structure, oils, the proper treatment is very much dose-dependent and considers pre-existing vulnerabilities as to account for that?

A. Pre-existing what?

Q. I say pre-existing vulnerabilities. Sort of like a

pre-existing mental health disorder such as bipolar?

A. Yes. Yes, those things have to be taken into consideration. There may be some people you don't do a trial for them if they have significant psychiatric history. If done correctly at trial, it's simply a way to find out if this is right for this person and sometimes it's not, and those people should be off to other forms of therapy for sure.

Q. So in your current practice, what sort of psychological disorder ... I guess we'll start with: Do you make a diagnosis of a psychological disorder if a patient comes in to see you?

A. No, I insist that that be done by other professionals because I saw that as a conflict of interest and so did the College.

Q. So prior to prescribing medical cannabis in your practice for psychological symptoms or psychological disorder, do you require a diagnosis first before you move to treatment and a prescription for cannabis?

A. I do, yes. I ask other people to have that diagnosis and for them to prove that there has been a diagnosis made by another health professional of some sort.

Q. So in every occurrence, putting aside you putting a

prescription or treatment for a physiological symptom or pain, but as it comes to treating psychological disorders or symptoms with cannabis you always require a diagnosis of some?

A. Yes.

Q. Okay. What sort of psychological disorders in your practice do you treat with cannabis?

A. The full spectrum of anxiety, depression, PTSD, insomnia, ADHD is common. So it really would include a fair spectrum of things. We don't get into the sub-diagnoses like personality disorders or things like that, they tend to belong to the bigger groups anyway.

Q. In your current practice, a patient comes to you for the first time, they present to you sort of proof that they have a diagnosis, a psychological diagnosis, how do you go about sort of assessing whether or not they're a suitable candidate to be involved in your structure for cannabis treatment?

A. Well, marijuana is not a first line therapy; they must have tried other things. And most people have tried many things before they actually knock on our door to see if this is an option for their therapy.

So it's not typically something that some ... you know, the first line of therapy that anyone has tried, it's probably way

down the line of things that could be offered for that person's symptoms. Does that answer your question?

Q. Yes. How do you go about determining what dose they should be on?

A. The dose is dependent on the trial, and trials always start at subclinical levels, meaning that they're started on doses so low they don't feel them and the tolerance is allowed to develop over several days. It could probably take two to three weeks to reach a therapeutic level. So if done in that way started so low and increased very slowly every four to five days they will reach a therapeutic level in a couple of weeks and then the decision is made, Is this for you.

If it does not improve their symptoms, makes them worse in any way we abort that program or that trial. If it has given them some benefit we may adjust some strains and the doses slightly and at no point should they reach a point where they were impaired.

So the goal is simply titration so slow, starting very low, to the point where a trial shows if it's useful or not. They do not need to be impaired at any time during the process of titration to the therapeutic level and that's an important aspect.

Q. How long do these trials typically last with a patient from first time you see them to a decision that, okay, they are a suitable candidate? How long of sort of trial are they on usually?

A. For someone who's never tried marijuana on their own it could be a month or a month and a half. For someone who's been a long-term smoker before they walked in the door probably, you know, strains off the street it's typically a little faster, although those people are harder to train sometimes, you know, in the correct way of doing things than someone who's starting right from scratch.

Q. And what do you mean "harder to train"?

A. Well, these people tend to think they know what's best for them, they've already tried. They're harder to teach: I know ... I know how to do this, don't try to tell me what to do. Those people are very difficult sometimes to bring down to a non-smoke version of therapy which we feel is the safest way to go at this point.

Q. And there are a number of things though I want to explore, one is the cost of a therapeutic dose, the other things are sort of some of the safeguards, including people that sort of resistant to being told how to take it. But before I get

there, so your current practice does it involve ... when you prescribe today medical cannabis, what form of ingestion do your patients take medical cannabis?

A. They will start with oils only.

Q. Okay. And the reason why you moved to oils was why?

A. Because it's reproducible and it's ... you know, when you smoke something the difference between a small dose and a big dose is indiscernible, whereas an oil you can titrate in drops or mils to, you know, slowly up the scale to the therapeutic level and it's reproducible once you hit that place and reproducibility is called stability.

Q. So it's more accurate in the sense of the patient ... you know, what the patient is getting at what dosage?

A. Yes.

Q. Versus smoking. It's a bit of a wild card and depends on how they do it, how they ingest it?

A. Smoking is almost impossible to reproduce on a daily basis because the dose changes so much and it's just a very frustrating place to ... you get it one day and the next day it's too little or too much and there's frustration there and people don't benefit from it as often.

Q. Back when you were treating Lionel Desmond, and we're

going to get into the interactions you had with him, how was he consuming cannabis, medical cannabis, for his symptoms of PTSD and major depressive disorder?

A. He came in as a smoker and he was one of those guys that we tried to teach to use oils and I know ... and certainly CBD as well, of course, but I think the last time I made notes on the chart was that he was still smoking more than he should, and he was implementing CBD, however, which is a major stabilizing aspect to the use of marijuana. But he was still smoking more than I'd like to see.

(10:58:08)

Q. So ideally, I guess, if Lionel Desmond were to be able to be treated by you today would you have given him a prescription for ... knowing now the shift, would you have given him a prescription and said you ingest it by smoking or would you have said you have to take it by way of oils?

A. The base treatment is still oils at this point. People still like to have a little smoke here and there just for maybe the effects or perhaps near bedtime, but the oils are still in the background as main form of therapy.

Q. So you would have promoted that form of treatment in terms of heavy focus on the oils?

A. Yes.

Q. Because it was more controllable?

A. Controllable, yeah.

Q. And more consistent in assessing results?

A. Right.

Q. You talked a little bit about in general sort of the concerns you had if somebody is ingesting it by smoking and how it's hard to predict how much they're getting and how effective ultimately it is. How do you safeguard between a patient who has other pharmaceutical drugs, for example, for depression, anxiety, post-traumatic stress disorder, they're given traditional prescriptions in, say, pill form, how do you balance that with a patient that wants to then start medical cannabis? Are you concerned about an interaction between pharmaceutical drugs and cannabis?

A. There are inter-reactions and, again, it starts so low you feel nothing. If someone is on medication, for instance, and they're even thinking in the future that they'd like to be able to have the option to come off those medications by their prescribing physician, a trial of medical marijuana would include again start below where they feel anything and slowly titrate. It gives the liver a chance to change the enzyme

production for the removal of these products and it should have little or no change in the effect of the current therapy at this point.

So basically it's always go ... start so low they feel nothing and titrate very slowly up to the point where they say this is okay or not and the trial, again, if they don't do well with it is done. If it does well and the people are benefiting then they have the options to consider maybe with their current prescribing physicians to consider trials off of some medications.

Q. So do any of your current patients have sort of traditional prescriptions for post-traumatic stress disorder, depression, coupled with your prescriptions for cannabis?

A. Yes.

Q. And are there risks involved there?

A. There's risk with every prescription.

Q. Yes.

A. Every treatment has a risk. Pharmaceuticals have a risk; I know they're significant. Marijuana has a risk so it's co-monitor, and that's why we have coaches and that's why give people the option to report any problems that they have with therapies. And, you know, as we proceed we proceed carefully

and with an open door to say if you've had problems you would stop it or come in and talk about it.

Q. From your perspective in your program, do you prefer to have a patient who has, say, PTSD, diagnosed PTSD, and major depressive disorder, do you prefer that they not have pharmaceutical drugs? Do you prefer if they're off of all of those drugs and just cannabis or ...

A. It's not what I prefer it's what people walk in the door with. They certainly ... they typically would not come in ... if you're on medications they would not come in if they're happy. If they're doing well, that's fine they're doing well. And medications work for many people. I'm not ... you know I'm not certainly saying that. Those people that are not happy, they either can't see the rest of their lives on these medications, they would like another option to potentially reduce the pharmaceuticals or not. Some people remain on these things and simply combine marijuana as an additional therapy for additional benefits.

So really, I'm not telling people they have to come off pills. If it works for them that's perfect. If they would like to reduce them they may go back after a successful trial on marijuana and ask their prescribing physician to try off some of

the medications they're currently on to reduce those side effects and there's many. Many side effects.

Q. I'm trying to think of a way to put this, obviously you weren't present. Earlier a few weeks back, we heard from a psychiatrist, Dr. Rahman, who had been a psychiatrist that interacted with Lionel Desmond in the ER, and he was specifically asked when prescribing the pharmaceutical drug, a traditional drug, for therapy for PTSD/major depressive order, he was of the view that a patient should not be consuming cannabis combined with that traditional method of pharmaceutical treatment.

Are you aware of any sort of consensus amongst doctors that it should, could or should not be combined or are you aware that there's a conflict there, different doctors take different views?

A. Any time where there's more than one therapy it's complex and it's hard to decide what's going on. So if someone is on cannabis and they are trying a medication it adds too many variables to allow a physician to say, you know, is this an effective therapy or not. It sometimes is better to start with just one thing and try that and see how that goes if that helps some. And another therapy has ... maybe another pill has to be

added to that for additional benefit that's fine, but it's one thing at a time.

I think someone who is on marijuana, especially if it's just a variable marijuana off the street that's too variable to add a medication to that, a pharmaceutical medication, because marijuana off the street is too variable and I would have to agree that that should stop before a medication should try.

Now, if they're on medical marijuana and it's very stable and it's reproducible there would be an option, I think, at this point in the thinking to add another medication to that to see if there's further benefit or not because then you have two stable, you know, potential treatments on the go. It's like adding one pill to another pill, you are simply adding things and see how that goes. You don't know ahead of time, you know, which one is going to work.

Q. In terms of a patient, such as Lionel Desmond, for example, he appears in front of you he says he'd like to try cannabis and see if that works for the treatment of PTSD and his major depressive disorder and he indicates to you, I'm off all my medications, do you go back and sort of check to see the medical history with, say, Lionel Desmond or to confirm that, in fact, he isn't getting those prescriptions?

A. He should be a reliable enough source to say you know I'm on pills or not on pills. I would have to ... I don't do drug screens on people to say, you know, Is that correct or incorrect.

I mean, he certainly was pretty straightforward. He had stopped his medications ahead of time, he didn't like them and had a lot of side effects. And he had tried the marijuana on his own off the street, found it somewhat helpful and I think he wanted to have, you know, a more medical idea of cannabis use.

Q. So in your practice you would take the information directly from the patient as opposed to I'm going to double-check by checking the charts of previous doctors with his consent?

A. Yeah, I mean, if I had a suspicion of some sort I might check, but, I mean, most people are pretty straightforward. If they didn't know what I was on or things like that, What pills are you taking? I don't know. Well, we'd have to find out first. We would check with the pharmacy and we typically ask them to bring in their pharmacy records anyway if they're on pharmaceuticals. So we would have that information right from day one.

Q. I'm wondering, Your Honour, we've hit about an hour

mark. I just want to check with the witness to see if he would like a break.

A. I'm okay so far.

Q. Okay.

THE COURT: All right. We'll give it another 15 minutes or 20 minutes then we'll take a break.

MR. RUSSELL: Thank you, Your Honour.

THE COURT: Thank you.

MR. RUSSELL: Is it fair to say that each patient that comes in and is treated for medical psychological disorders and symptoms with medical cannabis that there's an element of a trial with pretty much every patient?

(11:08:01)

A. Everything we do is a trial in medicine. You start a pill it's a trial. You start medical marijuana in a reproducible way it's a trial. So the decision is made after the response. Everybody is different so we can't predict even if we know something or we think we know something. It's different for every patient.

Q. You used the phrase "therapeutic stability" earlier on, I believe you used that phrase.

A. In context of marijuana?

Q. Yes.

A. Yes.

Q. What is therapeutic stability in the context of treating psychological disorders and symptoms with marijuana?

A. It would simply be the reduction of symptoms in a predictable way.

Q. And how do you know you've reached the point of therapeutic stability with a patient?

A. It's a subjective response of the patient in terms of what symptom you're modify- ... which one you are monitoring. Everything in psychiatry is based on the patient's subjective reporting of anxiety is better, depression is better, sleep, pain, whatever the factor is. There's no easy subject or objective way to measure those things, it's simply a subjective report of reduction of symptoms or not.

Q. How do you do this monitoring? How do you do that check and balance to see if things are going towards therapeutic stability? How do you ... how are you assessing that?

A. Follow-up appointments or talk to people. You know, they can report through their coach or they can report to me. And if they've been told ahead of time that things are worse you stop the medication and you let us know what's going on.

Q. I'm nearing sort of the end of sort of the general finding out about your practice and the differences with cannabis. You currently use coaches in your treatment structure?

A. Yes.

Q. How many coaches to you have?

A. Eight, I think.

Q. What are the various sort of backgrounds of these coaches?

A. They would be ... I would say all of them have university degrees in something, they're at that level of education. They're self-trained by our group to know what to ask, what to monitor and how to do the process so it's in-house training. There's no actual ... there are actual courses now available but I think our in-house training is probably more valuable than any of the courses that I've looked at to see if they would offer anything above and beyond what we already teach.

Q. And is there compensation for these coaches?

A. They work on the same basis of, you know, all coaches. They would receive some benefit from the companies that they work with.

Q. And do they ... their sort of billing structure, so do those coaches work for you?

A. They work with me I would say.

Q. Okay.

A. Yeah. I do not pay them.

Q. So they are paid by?

A. By whatever benefits they can achieve otherwise.

Q. From the supplier, I guess?

A. Right.

Q. The cannabis supplier?

A. Correct, yeah.

Q. What is their current role? What do they do in relation to a patient in your current structure? What's the role of the coach as it is today in your practice structure?

A. The biggest role is to answer daily questions. As someone starts a trial we would outline a trial in a standard way but everybody is so different that they need to have feedback ability to someone who has experience to say, Well, if this has happened this is what you do next. So they're adjusting things based on the variability that each patient has to reach the therapeutic point without side effects.

Q. So are they adjusting how much cannabis is consumed by

a particular patient or are they recommending how much they should or shouldn't consume?

A. The patient is ... determines that himself by the response.

Q. Okay. But does the coach get involved in making any recommendations about you should try some more, you should try less?

A. Again, it's based on the patient's response. If they're doing well at level A that's perfect. If they need to go a little higher to get that same response that the next person had at level A they might be on level B. So, you know, it's an individual response.

Q. Very early on in your evidence you talked about ... I can't remember your exact words but you had talked about veterans and almost in the context of a social structure I guess, an interaction ...

A. Yes.

Q. ... and the importance of that sort of structure and support. In your current setup do you have any sort of support systems for veterans outside of prescribed cannabis and ...

A. Yes, we have programs for vets to participate in what we call weekly events. It's just an excuse to come in to do ...

interact with people. And in the summer we would have at ... we have a lodge where people would go fishing and learn archery or music or boating and yoga. You know, we would have ten different things for people to, you know, participate.

They're more just things that people might be interested in, art therapy, music are the big ones, where they would just ... every week they would look forward to coming and being with the other guys and interact in any way. We try to keep it light and there's ... you know, we try not to get people in to talk about the wartimes too much, it's more social interaction.

Again, they have difficulty trying to find a sense of identity in our society once they've lost it from belonging to the military or the RCMP and some people need a new source of identity to interact with friends and other like-minded people.

Q. And seeing and having an opportunity to discuss the social aspect with your patients and those social supports, have they found that that's been helpful in their treatment?

A. I think so. People make connections all the time and they say, Oh, you just live down the street from me, I didn't even know. Or they're increasing their social network and becoming interested in things: I haven't played my guitar for 20 years or ... and some of the guys are now doing music to nursing

homes or to clubs and places like that and starting to have fun, for instance. And fishing is a big deal. You know, guys are getting an excuse to go out and catch a fish together, learn archery perhaps.

Q. And you indicated sort of almost a weekly thing. Do you ... what sort of physical structures or buildings ... do you own these buildings or rent these building to allow that to take place or how does it work?

A. Our home in the wilderness is what we do in the summer. We use that as the source and in the winter wherever ... the roads are terrible out there, we ... I use my office in Fredericton as a weekly meeting place.

Q. And roughly in the wintertime your office in Fredericton as sort of a meeting place, how many patients typically would you see maybe in the run of a week interacting at your office?

A. At those events?

Q. Yes.

A. Could be 10, 15, 20.

Q. And are you, as a rule, present during this period of time?

A. Yes, if I can be. I mean, I'll probably miss this

week, but I'm there most of the time. And we have guys that are what we call counsellors. They've taken counseling courses to help people in crisis, and those same counsellors would be guys that I would send out to say, Listen, I've heard so-and-so is not doing well, do you mind doing a home visit and they would do that on a regular basis as well. So they're on standby when I hear someone is having an issue to make a social contact or see how they're ... you know, how they're making out.

Q. Would you say that this structure is pretty time consuming on your part ...

A. Very.

Q. ... for that?

A. Very, yeah. But worthwhile for sure, yeah.

Q. I just ... and I know it's a sensitive topic but I'd like to cover it. So billings generally, a patient comes to you, they have a pre-existing diagnosis, they're determined to be suitable for cannabis-based treatment and they're prescribed cannabis, how does the billing structure work?

A. For me?

Q. Yeah.

A. I bill Medicare and DVA for forms and things like that and Workmen's Comp. and that's it. I do not have shares in any

company and I do not participate in any of the funding that comes from licensed producers to the educators, that's arm's length.

Q. And is there any financial compensation from the companies providing the cannabis to the patient and is there any financial structure where they provide financial support to you or payment to you?

A. No.

MR. RUSSELL: Your Honour, at this point I plan to turn to Lionel Desmond and his interactions.

THE COURT: All right. So we'll take a break and come back maybe around 11:30 then, 15 minutes or thereabouts. Thank you, Dr. Smith.

COURT RECESSED (11:19 HRS.)

COURT RESUMED (11:38 HRS)

THE COURT: Mr. Russell?

MR. RUSSELL: So, Doctor, we know Lionel Desmond was your patient. Do you recall when he first became your patient?

A. July of '15.

Q. July?

A. July 2015.

Q. All right. And do you recall how long he had been

your patient?

A. That was the first time I met him ... is that what you mean?

Q. Yes, I guess, yeah.

A. That was the first time I met him and up until February of '16.

Q. So from July 2015 and the last contact with Lionel Desmond, either by phone or in person, would have been?

A. February.

Q. February of 2016?

A. Right.

Q. So approximately seven months?

A. Yes.

Q. Do you know how he became either referred or reached out to your office, do you remember how that happened?

A. He was friends with some of the personnel at MFT and they had referred him to me as a potential, you know, patient who would benefit from this therapy.

Q. MFT is Marijuana for Trauma?

A. Yes.

Q. I'm going to show you Exhibit 140.

EXHIBIT P-140 - DESMOND MEDICAL RECORDS OF DR. SMITH - 48 PAGES

Q. Doctor, this in total, Exhibit 140, is 48 pages in total. This ultimately is your records as it relates to all your time with Lionel Desmond as your patient?

A. Yes.

Q. In particular, though, I want to start at page 21. Zoom in a little bit. So there's a patient assessment form here, it's filled out, Lionel Desmond, date of birth, and an address. Patient assessment form for patient seeking a medical cannabis prescription. Is this your form?

A. No, I think that was Marijuana for Trauma's form.

Q. All right. And somehow this ends up in your file as it relates to Lionel Desmond.

A. Right.

Q. Do you know how you got it?

A. I think he brought it in with him.

Q. All right. And normally he would have brought that in with him on the first visit?

A. Yes.

Q. If we could turn to page 23 and if we look down at the bottom, Doctor, again it's the same patient assessment form, which is the third page, three of three, and at the bottom it's signed Lionel Desmond, February 2, 2015. So I presume this was

signed prior to him ever engaging you in July of 2015?

A. Yeah.

Q. And the note indicates, "Cannabis helps me sleep better without me waking up continuously through the night. Also takes my mind off the therapeutic events that I have endured in Afghanistan."

A. Yes.

Q. Now recognizing you obviously weren't there for this being filled out but did you understand, is this sort of Lionel Desmond's account?

A. His writing? Based on his signature it could be. It might have been someone else's, I'm not sure.

Q. But it was your understanding when you received this that this sort of was Lionel Desmond's account for ...

A. Yes, I mean, he'd signed it so either he had directed what was written there as his information.

Q. So there are a few things on this page. First it indicates six grams a day, do you know what that was in reference to?

A. No, that was pre my involvement. So whether that's what he was actually trying or doing on his own, you know, people were buying off the street and using things like this.

Q. And just below that it says ingested method and it says "inhalation/smoke" and that's ticked off?

A. Yes.

Q. Is that consistent with what he indicated to you when you first met with him?

A. Yes.

Q. And that was how he was consuming cannabis?

A. Right.

Q. And over to the right, and again recognizing you weren't there for this sort of assessment form, it's hard to see in that shaded box but it says what are your treatment goals. It's checked off "improve sleep"?

A. Yes.

Q. Is that something that he discussed with you as well on July 1st?

A. Yes.

Q. Or July 2nd, sorry.

A. Yes.

Q. What do you recall him indicating his treatment goals were when you met with him on July 2nd, what was he looking for?

A. He was hoping to be relieved of some of his symptoms of PTSD which includes insomnia and, you know, thinking about

suicide and anger, all the symptoms that were on my question list there. He was ... I think he had already found that it was somewhat useful.

Q. And we're going to get into the details of what you discussed with him and what he was indicating to you were his sort of treatment goals or the underlying things he was dealing with. I notice here on this form "reduce pain", "improve daily function", "improve appetite", "improve mood", they are checked off here but are some of those things items that you would have discussed with him on July 2nd?

A. Pain is of primary importance and sleep, those are the two key factors and then all the other symptoms are, you know, we're interested in all that stuff.

Q. If we look to page 22 so this is page two of that assessment form, this appears to be filled out, it's obviously filled out by someone and it's a rating of symptoms, do you see that? Well, I guess, first we see primary condition, we see PTSD marked in?

A. Yes.

Q. At the top. When you first met with Lionel Desmond on July 2, 2015, were you able to confirm that he was, in fact, diagnosed with PTSD?

A. Yeah, he brought notes from Dr. Joshi which was one of the military docs at the time and, you know, he had a diagnosis on there with his signature on that, Dr. Joshi.

Q. Below that there's a number of symptoms where presuming there he was asked to rate out of five being the most significant and what is scored as five are muscle spasms, anxiety, depression, sleep disturbance, low energy. So those five, five out of five scoring as symptoms that he was dealing with being the most significant, did he discuss those items with you on July 2nd?

A. I would have looked at that. I can't remember, you know, dwelling on this one but I would have looked at the information, I would have read Dr. Joshi's notes there, and that would have been part of what we discussed.

Q. Before we get into specifics and we'll turn to maybe page ten of that same Exhibit 140. What do you recall generally of your interaction with Lionel Desmond on July 2, 2015? How would you describe sort of his manner or presentation to you in your meeting with him?

A. Well, Lionel was really a likeable guy right from the beginning, easy to talk to. He was very easy to ... he had a good memory and he talked about, well, we would have talked

about his career and, you know, how he interacted in that way. He was very forthcoming so, you know, if I asked him a question there wasn't hesitation or I didn't have to draw things out of him, it was always very flowing conversations and so on and he had a really interesting sense of humor. He was ... he would always have a pleasant way of, you know, framing things and does that kind of answer your question.

Q. Yeah, and I guess did you ever get any sense that at any point that he was ever sort of holding back sharing certain information with you?

(11:48:00)

A. I didn't get that feeling, no. I mean, obviously I've asked that question many times since then but I can't remember him presenting that way, it was always so easy to flow, he answered questions very quickly, he talked about his emotions and feelings very easily and he wore his heart on his sleeve sort of thing.

Q. Did you ever get any sort of sense that maybe what he's giving me is untrue or sort of misrepresenting, did you ever get any of that sense from him?

A. No, I didn't have that feeling at all, no.

Q. If we look, we're going to start going over a few

things on page ten of your report, Doctor. If you do need it in hard copy, it would be Volume 3 of 140.

A. I can read that pretty good, yeah.

Q. Okay. So we see, I guess, two different, if we scroll down just a little bit, I guess we see what appears to be two different handwritings or printings here. Did you fill out this entire form, sort of a template where it says name, Lionel Desmond, did you write down "Lionel Desmond" or who filled that out?

A. No, that ... this form is one that we ask them to complete on their own and then I would use that as a starting place for me to make notes and talk. So the notes that are written in on top of ... that's my writing for sure. Like, for instance, "Lionel Desmond", the dates and so on, that's his writing and so mine are the notes in between.

Q. When he appeared at your office that day, do you recall if he was with anyone during your time with him or was he alone?

A. I think he was alone.

Q. So we'll go through a few things and this is a standardized form that you were using when you're assessing patients for the first time?

A. Yes, we've updated that many times but that's what we were using then so ...

Q. If we look through down to family doctor, it indicates no family doctor so that's what Lionel Desmond would have advised you?

A. Correct.

Q. Did you get a sense of, did you ask him, do you recall, if he had seen other doctors, what other doctors he had been seeing?

A. He had been on medication so I assumed he'd had contact with OSI which is usually responsible for that but I don't think he had had other doctors that he was working with really.

Q. It says "military service" and it indicates dates of September 23, 2014 to June 26, 2015 and below it it says task force 07, Opathena, am I pronouncing that right?

A. It's Ethiopia.

Q. Oh, Ethiopia. Afghanistan.

A. Yeah.

Q. This information presumably came from him?

A. Yes.

Q. Did you explore what it was that he did while he was

in the military during that period of time?

A. Very superficially. My policy is not to get too much into details on purpose because if they go into a flashback then I've lost them to being able to talk to them, they're in a different time and place if that happens so I would just briefly talk about his career and what he did generally and where he might have gone and on purpose don't ask him too many details about things, especially at the first visit. If I don't know someone, I don't ask them those questions.

Q. Do you need to know the particulars ... once you have a diagnosis, do you need to know the particulars prior to sort of coming up with a treatment plan, particulars of his trauma or experience?

A. Well, if I know he has PTSD and pain and insomnia, that's enough for me to talk to him about the other symptoms that we did ask him about, that's enough for me to say, you know, this could be a reasonable trial for you. Is that what you're asking?

Q. Well, I just wanted to know what your sort of assessment was, what information you had to know prior to deeming him to be a suitable candidate.

A. Yeah, I need to have a diagnosis and a general sketch

of where his ... what his career was all about, you know, where did the trauma come from, those sorts of things and what kind of treatments has he had so far and things like that.

Q. But the particular details of his direct trauma experience, are you saying you didn't really need to know that?

A. Well, I knew the history of Afghanistan 2007 and I think I've heard enough stories to be able to tell you a lot about it and so when I hear '07, I purposely don't ask too much because I know what went on and it was pretty nasty.

Q. So you sort of avoided the details with Lionel Desmond?

A. Yeah.

Q. I notice you have circled June 26, 2015 and there's a note underneath it, what does that note say?

A. "Just out of military." Where your hand is?

Q. Yes.

A. Yeah, he was out of the military June 26, '15.

Q. Okay.

A. Yeah.

Q. If we look below Afghanistan we see in brackets a word here, what's that word?

A. Concussion.

Q. So what information did you get about Lionel Desmond and concussions?

A. I'm interested, you know, a concussion can affect the cognitive ability of people and the unpredictability of who they are because of ... it depends on where the brain was concussed, but it's just information that we collect and it can become useful later if we get into neurofeedback, we'll talk about that I'm sure, Alpha-Theta therapy, because it's very useful for recapturing memory and ability to ... you know, the cognitive ability if someone has a concussion in addition to the PTSD.

Q. So I take it Lionel Desmond would have disclosed to you that he had concussions in the past?

A. That's what that means, yeah.

Q. Do you recall whether or not he indicated how that was affecting him in his day-to-day life or if it was affecting him or he believed?

A. No, I don't think that's something that most people could answer. It would be a pretty undefinable variable kind of ... I wouldn't expect someone to say, you know, I can't remember certain things necessarily because PTSD does similar things, lack of sleep does that so, you know, to be able to differentiate what concussion did in addition to PTSD or all its

other symptoms would be impossible.

Q. And I understand it's a specialized subset, medical subset, that could deal with what's referred to commonly as post concussion syndrome?

A. Absolutely, yeah.

Q. Did you explore or turn your mind to how a concussion may have played a role in Desmond's symptoms and treatment ultimately?

A. At this point I'm just getting to know him a little bit, I'm not analyzing the differential diagnosis from concussion to PTSD and there's such an overlap, it's very difficult. I'm just collecting information at this stage.

Q. So are there are any sort of medical concerns from treating psychological disorders, in Lionel Desmond's case, PTSD and major depressive disorder with medical cannabis, and this sort of outlying possibility of a concussion? Is there anything you're looking for or wanting to guard against?

A. It adds a degree of unpredictability. Concussion, it depends on what part of the brain was involved, it can certainly be a wild card, I guess that's how I think of it. It depends what part of the brain. If it's frontal, it's very emotional, you know, memories and visual and GPS kind of information,

depends what part of the brain it is, it's a wild card in my mind, it's unpredictable.

Q. So unpredictable and a wild card in the sense of the presentation of symptoms or accounting for presentation of symptoms?

A. Yes.

Q. Is there any sort of unpredictability and wild card as it relates to symptoms as a result of a concussion and the interaction with medical cannabis?

A. There wouldn't be enough ... I wouldn't have enough information to make that discernment. Once you know the patient and their symptoms that a treatment potentially could benefit then it's simply proceed cautiously and do a trial in a reasonable manner and follow up. So it's not that I'm sitting here thinking about concussion necessarily when I'm sitting with someone with PTSD. There's such an overlap it may be absolutely nothing added, it could be significant.

(11:58:04)

Q. At this time when that's raised, did you consider maybe before I gauge Lionel Desmond's suitability for this method of treatment that perhaps we should get more information or more of a specialized assessment as it relates to concussions

before embarking on this sort of course of treatment? Consulting another physician, for example.

A. Would it hold me back from doing a trial?

Q. Yes.

A. No. I would consider it a reasonable trial in the presence of concussion.

Q. And at any point during your treatment of Lionel Desmond did you ever seek out or receive information as it relates to Lionel Desmond and concussions?

A. No. The reality of getting a concussion evaluation done could be a year and a half, two years, to have a specialist do that sort of thing and if you didn't report it, most concussions probably were not reported, they just happened in the line of duty so to speak, it would probably not be approved for benefits that are paid by DVA. It could be 6 or 7000 bucks to do that evaluation. So unless there's reasonable grounds for a claim, DVA will say, We're not paying for it so there's practicalities around those ideas and the expertise available to look into that sort of thing is not readily available. It's there but it could take a long time.

Q. There's another note just below we have a Medicare number and below it I think there's a letter R.N. at, what is

that note?

A. Oh, we're talking about marital status, he's married, she is an R.N. at IWK in Nova Scotia.

Q. So it's referring to his wife?

A. Yes, yeah.

Q. Okay. And his wife you understood to be Shanna Desmond?

A. Yes. And to the right is a "female, eight years old, with mum".

Q. So that was understanding he had a daughter I believe?

A. Yes.

Q. At the very bottom, I guess you explored family history and past history with him?

A. Yes.

Q. And anything notable about his family history?

A. Just the diabetes.

Q. And past history, what did he indicate?

A. Now I didn't put anything there although Dr. Joshi had made some notes about that.

Q. And we'll get into the details of past history and what you knew at some point later but you indicate there's, if I'm reading this correctly, jaw surgery, laser eye surgery?

A. Yes, that was his writing there.

Q. That was his writing?

A. Yeah.

Q. Below it it looks to be your writing and what is that?

A. He has a pension for PTSD and then major depressive disorder, MDD.

Q. And did you explore how long that pension had been in effect or ...

A. Yeah, again I would have looked at Joshi's reports and I don't think he gave me pension information but he gave me the notes from Joshi that was ... so I knew he was pensioned for that.

Q. And the PTSD, major depressive disorder, where did that information come from?

A. Dr. Joshi.

Q. And we see to the right across from diabetes something circled and two words, what was that?

A. That's coach and Fabian was his chosen coach.

Q. So ...

A. I think he knew Fabian so he was ... you know, Fabian had agreed to be ... I always make sure that the coach is connected with the patient. Are you okay with being this

person's coach?

Q. So in terms of your first meeting with Lionel Desmond in July, did he already have Fabian as a coach?

A. Fabian was a friend of his. He had a lot of friends, he was that kind of guy, but Fabian would have been his contact probably through Marijuana for Trauma as well and a friend, does that answer your question?

Q. Okay. So Fabian was, I guess, assigned to be his coach?

A. Yes.

Q. And just, and I don't want to get into the details, but earlier you indicated that there was like diverging sense of philosophies between you and Marijuana for Trauma?

A. Yes.

Q. Was Fabian one of those members that you sort of had the difference in philosophy and approach?

A. Yes.

Q. Okay. And generally what was the ... what were the diverging views between you and Fabian?

A. Well, his attitude was smoke basically and if it wasn't better, smoke some more and I'm saying, no, that's the opposite to what we should be doing. So their attitude was

smoke was the answer to most things.

Q. And at the time that Lionel Desmond is getting treated by you, were the concerns there with respect to Fabian?

A. Yeah, I mean Fabian was exploring what worked and didn't work as well. It's not like we all knew the right way to do things at this point and he had his attitudes, I had mine, they were both in evolution and, in fairness, what worked for Fabian was lots of smoke and I think he probably told lots of people that that's what worked for him and go ahead and try that. I'm on the other hand saying, no, we're trying to do something different here and add CBD to everything and go to smaller doses.

Q. There are some notes, one in particular at the very top of the page, that there's a reference to a date in December but we're going to come back to that later, I want to keep things sort of in sequence, in order.

A. Okay.

Q. If we look to page 24 and 25 of this exhibit. So, Doctor, you referred to having information from Dr. Joshi who was a psychiatrist that had previously been involved in treating and assessing Lionel Desmond?

A. Yes.

Q. And you indicated that Lionel Desmond provided you with information regarding that?

A. He would have brought that on his first visit.

Q. So this is page one of two so you're saying Lionel Desmond would have brought this with him the first time you met with him in July?

A. Yes.

Q. And you're familiar with the contents of this?

A. Yes.

Q. And I'm going to get into some of the details later which would flow in more naturally. Did you ever receive any additional reports that were from Dr. Joshi as it related to his treatment of Lionel Desmond?

A. No, I think this was the only piece of information.

Q. Did you ever request sort of ... are there any other reports I should know about from Dr. Joshi, did you ever request that information?

A. I don't think so.

Q. Was there a particular reason why you didn't do that or didn't feel that you had to?

A. I thought this information was pretty complete in terms of my involvement for a trial.

Q. And so I'm just going to look very briefly. It indicates the report is from September 28, 2011 and you meet with Lionel Desmond July 2nd of 2015.

A. Right.

Q. And there appears clearly on this there was a diagnosis and we'll review that. Was there a reason why maybe you weren't looking for something a little more recent?

A. I had Lionel there to tell me what was recent, what have you tried since then. He had tried several medications which we charted, what kind of therapies have you had, psychotherapy for instance or things like that. I mean, Lionel was pretty clear on details like that so it wasn't that I had to have, you know, back-up information more than, you know, his memory.

Q. So in general, though, if you're trying to get a handle on, you know, this is treatment of last resort, cannabis.

A. Yeah.

Q. And you're trying to get a handle on what has worked in the past, how he's reacted to it, do you see that maybe between 2011 and 2015 there's a bit of a gap there?

A. Yes, and Lionel gave information about the medications he had tried and other therapies and so on as well.

Q. And you didn't feel as though there was a need to sort of pry further in getting actual charts and actual reports?

A. I thought his memory was pretty clear. He had a good recount of, you know, what he had tried and what his response to those things were.

(12:08:02)

Q. And do you recall if you reviewed elements of this report with Lionel Desmond to confirm what was reported there?

A. Yes, I would have said I read your ... I mean, he presented this so I would have read it and probably asked a few questions. I can't remember those details now but we would have gone through this together.

Q. Okay. And just I'm going to refer to certain passages. Where it says "Personal History": "Corporal Desmond describes his childhood as difficult. He experienced severe physical and verbal abuse." Midway through: "After his deployment to Afghanistan he became disillusioned with CF (which is Canadian Forces I believe)."

A. Yeah.

Q. "He does not like his present job of working in the band." Later on it says: "Corporal Desmond has significant financial difficulties." Do you recall if you reviewed those

things with him or got that information from him?

A. Yeah, I would have read it in front of or with him and we probably had discussed some of this stuff.

Q. It says: "He had co-signed a loan for his wife so that she can go to school to become an R.N. He is not sure about his decision as he now feels that their relationship may be heading toward separation."

A. Yeah.

Q. Did you review the sort of nature of how his relationship was with Shanna Desmond in July?

A. It would have come up and he had talked about the fact they've had struggles for a long time with, and this is back four years prior I think, and he said that was still ongoing. I can remember that.

Q. So you got the sense that the relationship struggles, that was still an issue that was occurring in 2015?

A. Yeah, you know, I had the feeling that things just ... they weren't right still. He had indicated they were still having problems, I remember that much.

Q. Did he get into the details about or elaborate further on this sort of he had gotten a loan to support her degree. Did he talk about that a little bit or did he give any sense to you?

A. Money was always an issue and he thought ... I think she spent money quicker than he could make it. And he always felt like he was always supporting her and things were not going well that way. I don't remember any more details, really, than that.

Q. So when you say money was always an issue, did you get the sense that that was an ongoing issue or concern for him?

A. Yes. I did have that feeling. Yeah.

Q. Did you get a sense that he might have been frustrated as a result of that?

A. Absolutely.

Q. On this particular report, it says, "Mental Status Examination". And on this particular date, Dr. Joshi said his mood was depressed, no suicidal ideation or violent thoughts. So were you familiar with that aspect of the report?

A. Yeah.

Q. And then at the bottom we see, "Diagnosis". "Axis I, post-traumatic stress disorder and major depressive episode."

A. Yeah.

Q. "Operational". What ... do you know what "operational" means in that context?

A. In the line of duty.

Q. Okay. And Axis III it says, "Recent jaw surgery." Axis IV, it says, "Marital difficulty. Separation from family. Deployment to Afghanistan in 2007." So you were aware of that diagnosis?

A. Yes.

Q. And, finally, it says, Axis V, "GAF 55 to 60." Do you know what that means?

A. It's a scale for depression. On a scale of ten being normal and zero very suicidal, the opposite end. So between 50 and 60 is reasonably depressed. On a scale of ... on the GAF scale, most people don't work under 70. That's a general ... just to give you an idea. And under 40 would be pretty serious suicidal thinking.

Q. Okay.

A. Yeah.

Q. And I understand that ... I guess if ... from a medical standpoint, if somebody gets diagnosed with PTSD or they get diagnosed with depression in a period of time, in say 2011, does that diagnosis stand and stand for they always have it every time forward?

A. No. Things can change. PTSD is a long-term diagnosis. Depression would vary, although if depression is a

part of PTSD, it's somewhat more likely to stay with time as well as a part of.

Q. And patients that you see that might have a diagnosis of PTSD and depression, they can present, I guess, differently during different points of time in their treatment?

A. Absolutely. I mean the ... in the definition of PTSD are mood swings. That's part of the definition of. So depression would be an intrinsic part of that diagnosis. You know, you wouldn't need major depressive disorder if ... if someone came in with PTSD, you would understand they had a degree of mood swings which would include depression.

Q. Okay. And I note on the date that this report was prepared, it said no suicidal ideation or violent thoughts. But that certainly can change and fluctuate as months, days, years go by?

A. Yes.

Q. So, again, I'm sort of wondering. When you assessed him on that particular date, were you ... had you turned your mind to, Maybe this isn't the full complete story of Lionel Desmond and his interaction with medical professionals.

A. Correct. That's just a spot in time. Those are the symptoms at that point. And we're creating another spot in time

on my notes, so .. and ...

Q. Yeah.

A. Yeah.

Q. So ... and we'll turn to page two at some point later. So if we look to page 11 of that exhibit, so this is the second page of your July 2nd, 2015 visit ... or meeting with Lionel Desmond ... appointment. So "Medications", there's nothing noted but I will get to medications.

A. Yeah.

Q. "Alcohol and tobacco intake, average day or week." And there's nothing noted there. Do you recall if Lionel Desmond had a conversation with you with respect to either alcohol or tobacco?

A. Yeah. From Joshi's report, I think, or other ... I knew he had abused alcohol in the past but it wasn't currently a big problem.

Q. Okay. Did he get into the extent, do you recall, of how bad or the level to which he consumed alcohol?

A. I mean it's standard procedure to get into alcohol heavily. I would daresay that most PTSD veterans would have dabbled in that. It's almost a hundred percent at some point in their recovery, typically before they get into medications and

things like that. That's the only thing they would have to drown their memories and help their sleep, perhaps, or pain sometimes.

Q. So do you recall with him if he was indicating to you whether or not alcohol had been or was currently a problem for him? Do you remember?

A. If alcohol was a problem, I would have made a note here. I think it probably was not an issue. I didn't make a note of it.

Q. Okay.

A. Yeah.

Q. I notice "Allergies". I guess that's pretty standard practice that you go through.

A. Yes.

Q. And there's nothing noted there.

A. Right.

Q. And it has "Other". And it says, "Do you have any ..." This is a standardized form, I understand. "Do you have concerns of undiagnosed issues, or that you have not had adequate medical care to this point, or that you would appreciate further evaluation of some of your medical concerns?"

What was the purpose, I guess, of this question? Why is it

there?

A. As an example, maybe someone had diabetes and they had had no care for that so far. I would ... as a family physician, I'd offer, you know, some treatment options around that or investigation, perhaps. So if they ... sometimes they'll come in with back pain that's tremendously worse since they got out of CF. I'll make a referral to a specialist or do some x-rays maybe; you know, that kind of thing. So it's just ... we're just fishing to see. There's so many major issues that didn't come up in the initial information base.

(12:18:07)

Q. Does this only apply to physiological symptoms or does it also apply to sort of psychological assessment and treatment?

A. It's just ... we're throwing a fish net out to see what else is there. And if ... and guys will come up with all kinds of stuff, just a simple question like that. They'll say, Oh, yeah, I've always wanted to talk about my problem here, and that might be something they've never had looked at before.

Q. And as it relates to Lionel Desmond specifically, did he voice or indicate to you, on this date or other dates, if he had any concerns with his medical care to that point?

A. I don't recall anything like that.

Q. Okay. And did he indicate there was sort of further evaluation of some sort that he wanted done?

A. No. If he did, I would have made a note here.

Q. We have, at the bottom of the page, under "Pain" ... I guess first starting with the left, what's that say? There's an ...

A. A ...

Q. ... arrow ...

A. A pension for low back. And then he has also tinnitus and hearing loss.

Q. And then we have, next to it some writing next to a stick figure. What's that?

A. The pain range ... yeah. He's just drawing what part of the body is involved here. So his spine, probably from mid thoracic down to the lumbar was involved with pain on a range from one to eight, even up to ten at times. So the pain was pretty good sometimes and pretty bad sometimes.

Q. And in the margin, we have ...

A. "THC".

Q. So what was ... that was you making the note, "THC". What's the purpose of you putting ...

A. I think I was just getting a feel for ... I mean he

had tried marijuana before I saw him, don't forget. And so I was getting a feel for what was helping a little bit. And I didn't specify THC was all he was using at this point. But if he had been on narcotics or anti-inflammatories, I would have listed it there too. So, really, the only thing he was using for pain at this point was marijuana.

Q. And did you understand, when he first met with you, where was he getting his cannabis? Did you have that discussion with him?

A. Ah ...

Q. Not ... you know, I'm not asking about did he get it off of Dealer ...

A. Yeah.

Q. ... "A" or ...

A. Did you get it from the street or ...

Q. Okay.

A. ... some buddies or ... no. I try not to ... you know, I'm not stupid. I know that, you know, there's lots of sources and there really is ... you know, if it's not medical marijuana, I know that it's potentially not a good source. And that's one thing. And I didn't want him to tell on his buddies either because, you know, in reality that's where some of that

may have come from. Yeah.

Q. If we look to page 12? Here specifically, we have a PTSD-related questionnaire. So you would have completed that with Lionel Desmond?

A. Yes.

Q. Generally, what's the purpose of the PTSD questionnaire?

A. Just to get a feel for the degree of the symptoms that are listed there.

Q. And below it, we have ... which is number two, it says, "Please provide a brief history of PTSD traumatic event with dates and location." And you have, "Afghanistan 2007".

A. Yeah.

Q. So can I take from that you sort of just did a peripheral sort of overview without the fine details?

A. Yeah.

Q. And you indicated earlier why you did that.

A. Right.

Q. So, below, I want you to sort of take us through ... before we get into the scoring, on the left it looks like it's a handwritten note that say "Meds".

A. Yeah. I asked him about what medications he had been

on in the past. Now these things, he was off at this point. He was on zopiclone, risperidone, Effexor, and Viagra.

Q. So what's the first drug ...

A. Zopiclone is a sleeping pill and risperidone is a major tranquilizer used to just calm you down, help you sleep sometimes. Effexor is strictly an antidepressant, and Viagra is for sexual ...

Q. Did he indicate at the time whether or not he was taking those medications as of July of 2015?

A. He was off these at this point.

Q. So it's sort of a past history of what he was prescribed.

A. Right.

Q. This ... the names of these drugs, do you recall where he got them? Is this something he just relayed to you verbally or did he have prescriptions with him or ...

A. No, he didn't bring prescriptions. He had been given that in the military, I assume. I can't remember those details. May have continued when he got out for a while but ... like the main issue was that he had been on them in the past. He wasn't on them anymore so ...

Q. And, typically, these particular types of drugs, in

your experience, is there some concerns that you would have if a patient had been taking them at various points combined with cannabis? Were there any sort of things or things to be kind of looking out for or concerns from your end?

A. So you're asking if he come on ... come in with those pills still on his list?

Q. Yes.

A. I would ask him why is he here now. That would be my first question. And I would assume the answer would be, I'm not real happy the way I feel on these medications. So, typically, I do not remove medications myself. I would then proceed to a very slow ... go slow low trial even with the medications, if that's what you're asking.

Q. Did he give you, in a conversation with him ... did he indicate how he felt he was reacting when he was taking those medications or why he stopped?

A. I made a note and I remember him saying ... he said he didn't like the medication. You know, if you asked me details, I'm not ... I don't remember those now. But he just said, The pills didn't work for me. The only thing that worked were the ... or the marijuana. He made a note of that, so ... yeah.

Q. So that takes us to the note in the right side. I

believe it's "THC" and something else. What's your note say?

A. This ... he's at one gram a day.

Q. And what was noted below that by you?

A. "Effective but just getting started."

Q. So what's that discussion about? So he indicates he's taking one gram a day?

A. That's where he was on marijuana, from whatever source, at about one gram a day at this point. So not a very big dose but it's a starting place.

Q. How much ... in everyday consumption terms how much is one gram?

A. It's equivalent to two marijuana cigarettes.

Q. All right. And if he says, "Effective but just getting ..." Did you say "started"?

A. "Just getting started." Yeah.

Q. What's this discussion about?

A. Well, I wanted to know ... I'm looking at what therapies he has. He's off the pills. He's on the marijuana. And he's just really early in the process of titrating up to a place that might work. You know, so a full trial probably because he can't get enough yet, has not really started yet.

Q. But he is initially reporting that he's having some

success in self-treating his symptoms with cannabis.

A. Right. It's enough for him to want to go further. I think that's the point there.

Q. We're going to go through ... he was asked to rate from zero to ten, ten being the most severe, the number of sort of symptoms. Do you recall doing that with him?

A. Yeah.

Q. And anxiety was scored at an eight?

A. Yes. These are his numbers that he wrote before he came in. That's ... because those are not my ... that's not my writing. So he would have ... as a part of filling out this form at home before he came in, those are his numbers.

Q. So very quick; anxiety, eight; hypervigilance, ten; depression, ten. I notice "depression" is circled. Did you circle it?

A. I think we stopped and ... yeah. I probably stopped and talked to him about that.

Q. Do you remember what he revealed to you about his depression?

A. I can't recall that now.

Q. Avoidance of trigger-related people and situations scored an eight. Flashbacks and intrusive memories, ten;

nightmares, six; disordered sense of blame for the events, five; stuck in severe emotions related to the events, six; anger and irritability, ten; poor concentration, nine; easily startled, eight; feeling disconnected from oneself and depersonalization, ten; sense of feeling that one's surroundings are not real, eight; suicidal thoughts, five. So would you have reviewed each one and have him discuss what he means by each one?

(12:28:04)

A. Yeah. We probably spent quite a bit of time on this list and I ... just get a ... getting a feel for where he is without medications and an early low dose of marijuana at this point. And probably he's filling out these numbers before he started the marijuana, my guess would be.

Q. So these numbers, do you know if they stood for how he was presenting the day of July 2nd, 2015 or did those numbers reflect prior to one gram a day self ...

A. If ...

Q. ... medication?

A. ... he was ... again, it would have been filled out at home, so I'm not quite sure. I think this is ... these are the numbers that he rates those symptoms at when they're at their worst.

Q. Okay. When they're at their worst.

A. Yeah.

Q. Was he instructed to rate them that way?

A. It was done at home, so nobody instructed him to do anything except fill the form out.

Q. Okay.

A. So ... really.

Q. Yeah.

A. Yeah.

Q. So I notice that he's got, for example, anger and irritability at a ten. Did you discuss with him what were examples of his anger and irritability and what were the triggers that led to that?

A. I don't remember those kind of details.

Q. No?

A. No.

Q. "Feeling disconnected from oneself and depersonalization." Was it ever explained to Lionel Desmond what depersonalization is?

A. Perhaps.

Q. By you?

A. We talked about those things and, you know, the

daydreams and you get into another state and when you come back, What time is it, and, Who do these hands belong to, and ... it's a dissociation state that ... extremely common as they get into flashbacks and, you know, remember what happened over there. They come back and they have to reorient themselves into this place and body right now, so ...

Q. At the bottom there's a handwritten note and it appears to be by ... was it by you that ... "homicidal thoughts"?

A. Yeah.

Q. So what's the significance of this? You noted it in, yourself.

A. Yeah. The zero beside it on the far right side means there were none. When you look at someone with this degree of symptoms, it's a logical next step to ask, you know, Do you have those homicidal thoughts?

Q. And do you ...

A. So I just wrote it out and said, no, there was ... that wasn't part of what ...

Q. And do you recall asking him if he had homicidal thoughts?

A. I wrote it down, so obviously I did. Yeah.

Q. And you said there was a zero beside it.

A. The zero is on the right.

Q. And that means he didn't.

A. He did not have. Yeah.

Q. Next page, 13, there's ... section four, it says, "What treatments have you had to this time and how effective they were." So, again, this is filled out by Lionel Desmond?

A. Yes.

Q. And ten being "very effective", any ... I guess if we start with the first one, "Psychotherapy" is circled and it scored an eight. Did you discuss with him who had provided the psychotherapy, what it was about it that he felt helpful?

A. I did. And I circled it because we talked about it. So it would have been ... you know, he only got out a month before I saw him, so it most likely happened in the CF, while he was still in. The reality of getting out takes rehab probably two months to start where they would organize things like that even. So the psychotherapy would have definitely happened in the CF, while he was still in.

Q. Did you, at any point, turn your mind to, Maybe I'd like to see those records just to see what it was, what was effective. I mean, clearly, he indicated that it was helpful.

Did you turn your mind to whether or not it would be important for you to get those records?

A. We would have ... those records probably are like a hundred pages long and not practical for me to see. And psychotherapy is all over the place. It's not a standard, you know, Did you get A, B, C? Everybody has an eclectic way of approaching psychotherapy. So how useful that was, I would ... even at this point, I probably wouldn't ask for those records. I would just say, What was your response? Is it something that you would want to do again or continue on with? Many people would say, No, never, or some people would say, Yes, for sure. So that would be more my approach. I'm not here to evaluate what previous therapy he had, just his response to it really.

Q. So you indicated very early on in your evidence that ... when we asked about cognitive behavioural therapy ... and I know that's different than psychotherapy. And you talked about elements of that ... you work that into your current practice in treating patients above and beyond prescriptions for cannabis.

A. Yes.

Q. When you're meeting with Lionel Desmond and in the time period that you had contact with him, had you turned your mind to sort of a multi-dimensional treatment plan for Lionel

Desmond above and beyond prescriptions for cannabis?

A. Yes. I mean it ... when we're evaluating someone at the first time, we're looking at the response to things. So we're always looking for ways of treatment forward. So his response to psychotherapy is that he was okay. He liked it. Worked well for him. It would ... in this case, until he's more stable, he probably wouldn't be a great candidate for it yet. But as he became more stable, it would be an option for therapy in the future for sure.

Q. Was there ever any discussion with Lionel Desmond that, I'd like to know more about your past medical history and the particular people you met with. Did you ever discuss that with him?

A. On a one-hour visit those kind of details are beyond the scope of what we look for. I'm getting a feel for the person and where he's been, what he's done so far as far as therapy. Those kinds of details are probably not something ... you know, that would come out as I get to know him. Yeah.

Q. And as you got to know him, did that come out?

A. Psychotherapy? Is that your question?

Q. Or just general past involvement with other healthcare providers and what, if anything, was helpful, what can be worked

into this treatment plan. Did that ever get discussed with him?

A. Well, it ... the circle of psychotherapy means we talk about psychotherapy. And his attitude was positive. A lot of guys would put a zero there and they would say, I'll never go back. An eight, to me, means that he was okay with that, he would like to continue. That's the only practical aspect that I'd be involved with.

Q. Okay. Were you aware of ... often, veterans have case managers?

A. Yes. They all have case managers. Yeah.

Q. Were you aware, during your seven months with Lionel Desmond, whether or not he had a case manager?

A. I ... my guess at this point was he probably did not or if he did it would just have been an initial visit.

Q. Okay.

A. And ... because it takes a month or two for rehab to begin. And I'm seeing him within, say, a month or so of getting out, or less. And if he had a case manager, he might have known their name, not develop a relationship yet.

Q. Did you get a sense of what level of treatment ... when he presents to you in July of 2015, did you get a sense from him in your conversations whether or not there was a

treatment structure worked in place for him that involved different medical professionals?

A. I can't recall that. No.

Q. If we turn to page 14 ...

THE COURT: Mr. Russell, at some point in time when it's convenient for you to break, we're going to break for lunch. It's 12:30.

MR. RUSSELL: I think we can break at this point, Your Honour. It wouldn't disrupt anything.

THE COURT: All right. So we just turned to page 14. When we come back, we'll use that as a starting point. All right. Thank you.

Thank you, Dr. Smith. We're going to adjourn for an hour. We'll come back at 1:30. Okay? Thank you.

COURT RECESSED (12:37 HRS)

COURT RESUMED (13:36 HRS)

THE COURT: Mr. Russell, you were at page 14.

MR. RUSSELL: Page 14, Your Honour, yes, Exhibit 140. So, Doctor, where we left off, I just have some general questions quickly about the standard form you use and the information you provided to Lionel Desmond. Page 14, there's a number of points. Again it referred to marijuana was sort of

the last resort therapy. It talks about obligations on the patient to disclose any sort of changes and symptoms and it's their responsibility to report any adverse side effects, and there's a number of things listed there I won't go over in great detail. Is that something you would have reviewed with Lionel Desmond, his obligations for participating?

A. I expected that he'd review it and, if he had any questions to let me know, but, no, we wouldn't have spent a lot of time there.

Q. And there were a number of consents where he checked off "yes" and he had agreed to follow-up visits, on page 15, periodic drug testing if requested, and any further diagnostic tests as deemed appropriate, he consented to all of those?

A. Yes.

Q. And then finally on this form there are a number of side effects that were listed - how cannabis can affect memory, it can exacerbate symptoms of schizophrenia. You would have reviewed those things with Lionel Desmond?

A. It would have been the standard "if you have any questions about anything, let me know" sort of thing, yeah.

Q. And if we turn to page 17 we see Lionel Desmond's signature and the date July 2nd, and then you have two names

listed down at the bottom, Fabian, and then you have wife, Shanna, RN in Nova Scotia.

A. Yes.

Q. What was the significance of noting those two at the end of the form?

A. Well, the witnesses - because Shanna was somewhat out of the picture, you know, living in another province - that the witness is either someone the person knows locally, such as Fabian, and/or a family member, if preferred, so that they're given permission to speak to me directly about his case and that it's not a breach of confidentiality for them to speak to me and vice versa if he's given permission to allow me to speak to these designated people. That's what a witness is.

Q. And so he had two designated witnesses, which would be Fabian, as you indicated?

A. Yeah.

Q. And his wife, Shanna?

A. Right.

Q. What was Fabian's last name? I never did get it.

A. Henry.

Q. Henry.

A. Yeah.

Q. So I won't ... There's a long note here dated November 16th/17th, we're going to return to that in a little while. So at the conclusion of this first assessment and meeting with Lionel Desmond, did you deem that he would have been a suitable candidate for a trial in your program?

A. I did, yes.

Q. Did he receive any sort of trial prescriptions as a result of ...

A. I gave him a starter prescription and then he would have spoken to the coaches for some time again, probably another hour or so, to give him, you know, instructions on how to do things right, what's right and what's wrong and things like that. That's what the coach's job was.

Q. About how to consume it, you mean?

A. Right. So they spend an hour with me and then probably at least an hour with the coach again, so, yeah.

Q. If we turn to page 19 of that exhibit ... I'm just going to quickly look at pages 19 through 20. So you indicated that you did write a prescription for Lionel Desmond.

A. Yeah.

Q. On July 2nd. And I guess the one on the previous page, 19, what's this here, is this the prescription?

A. Yes.

Q. And what was it for?

A. Five grams.

Q. And was there a particular strain or ...

A. No. As part of the education, you know, they're told about sativas, indicas, and CBD and things like that, so they were given the ability to choose what they feel would work and proceed forward. Yeah. And the idea of having two companies is ... In those days there were several licensed producers sold out or didn't have strains that they were looking for, so if they couldn't get it from Company A, they'd get it from Company B, and back and forth, so ...

Q. So this page 19, so he was prescribed five grams and it's to be taken from a company, Aphria?

A. Yes, I think so, that one.

Q. And page 20, I believe this is another prescription. Again it indicates five grams and from MedReleaf?

A. Right.

Q. So in total, is he prescribed 10 grams of cannabis per day by you as part of the trial?

A. Yes.

Q. How did you arrive at the quantity of consuming 10 or

up to 10 grams per day for his treatment?

A. Again, it was two companies. He probably wouldn't need anywheres near that dose, but it was access to two companies in case he bought, say, one month from one company and another month from the other company, up to the amount that worked. And at this point we were still trying to figure out the doses that were required by such people, and so it's not like we had a number that we said, Okay, under this number you have to work and so on. So, again, we taught them to use the minimum dose that was effective, so they, if they had a 10 prescription and two grams a day worked, that's what they were stuck with or that's what they should stick with.

Q. So based on the prescription, I mean you indicated earlier that one gram was equivalent to two sort of joints?

A. Yeah.

Q. If you took 10 grams, that's equivalent to 20 joints a day?

A. Yeah, maximum, yeah.

Q. So did you have a discussion with Lionel Desmond as to how much he should start out with trying?

A. The education that we give each person is really slow and go slow ... start low and go slow. So it would have been

less than a gram for the beginning and then to work up from there until he ... There's a certain amount of tolerance that's being developed as you go through time, so he would move up to the point where he felt the effects he was hoping for.

Q. And this was going to be ... Lionel Desmond was going to ingest the cannabis by smoking?

A. He would have been told at this point that CBD is an important component and that the oils are very effective. We didn't say you couldn't smoke.

Q. Okay.

A. He had the option to do what he felt was working.

Q. And ultimately you meet with him at some point later - how did he ingest it?

A. He probably smoked most. I assume he tried some oils, and he was using strains that had CBD, so that was part of our criteria of safety. I think he did ... I made a note, you'll notice in the next few pages, that he was smoking more than anything else. That'll come up in the next visit, so ...

Q. Okay. How long was the prescription for?

A. Four months.

Q. And was there a purpose why it was limited to four months?

A. Yeah. It forces them to come back and say I want to get another prescription from you. So I usually made an appointment for two or three months, with the idea of seeing them back within that period of time. If they're doing it correctly, then we would continue on with bigger doses or not bigger doses but longer periods of times.

Q. So if we turn to page 3, Doctor, you would agree that this is the first page of a record that indicates your second appointment with Lionel Desmond from October 1st, 2015?

A. Yes.

Q. And would you have scheduled that appointment before him leaving in July?

A. Yes.

Q. And overall what was the purpose of this follow-up appointment?

A. Just to check back on his progress.

(13:45:58)

Q. And so at this point we have filled out Diagnosis - PTSD, under (a), and under (b), MDD, that's major depressive disorder?

A. Yes.

Q. And then, again, we have "history of concussion" and

there's a mark there. What's the significance?

A. It's positive, it means he does.

Q. So do you recall any sort of discussion with Lionel Desmond regarding the concussions in the second visit?

A. Just that as we're going through, this is all my writing in there, in this page, so we again confirmed that he had a concussion. There wouldn't be too many conclusions that we could make at this point. It's just, all right, it's there, I'm just making my records more ... as complete as I need to have it.

Q. And overall, when he presented to you in this visit, October 1st ... I guess, are you able to recall how long the July visit was, the initial assessment?

A. They were a minimum of hour, hour and a half. They took a while.

Q. Do you recall this October visit, how long this one was?

A. It's not like I have a memory of that but they notoriously were all at least an hour. I schedule an hour.

Q. Okay.

A. And lots of times ... And if they went 10 minutes less or 15 minutes more it wouldn't matter, you know, we'd just

keep going. The end of the day would be the end of the day, whenever it was so ...

Q. All right. So what was your overall impression of Lionel Desmond in the visit on October 1st? How did he seem to you?

A. I thought he was doing fairly well. His numbers were better and he was ... I think you'll see here he's drinking a couple beer a week, but I wasn't worried about that, that he had significant improvement in his symptoms. I thought he was doing fairly well.

Q. Did he report to you any sort of adverse side effects or adverse reactions to cannabis on this date?

A. I don't think so. If there was, I would have made a note.

Q. On the first page we see "Current Treatments" and there's a number of them listed, but there's nothing checked off or noted. Do you recall having a discussion with him as to what other treatments he might have been undergoing at that time or if there were any?

A. If he was into something I probably would have made a note, so I assume there wasn't too much other treatments going on still. But, like, it's not like I have memory of that kind

of stuff but ...

Q. All right. And "Current Medications", what do you have listed?

A. "Current Treatments" you mean?

Q. Right at the bottom there, it says "Current Medications".

A. Oh, "Off all medications except MM (means medical marijuana). Much better off meds."

Q. And is that information that he reported to you?

A. Yes.

Q. Did he elaborate what he meant by "much better off being off the meds"?

A. He probably did. I don't ... The details ... I mean, typically, there's a lot of side effects, you know, such as, you know, grogginess and feeling, the word "zombie" always comes up with these guys, they all felt like a zombie and, you know, their sex drive was gone and they didn't ... they can't think and they're just existing. That's the typical explanation. Now those details I don't remember for Lionel, specifically; I'm just talking in general.

Q. All right. If we turn to the next page, it's filled out here "How long have you been on medical marijuana?" And it

says "3 months".

A. Yeah.

Q. And then it says "Dose" - 10 grams per day.

A. Yeah.

Q. So do I take it from this that he was using the 10 grams per day?

A. No, he ...

Q. Do you get a sense of how much he was using?

A. That's his ceiling dose.

Q. Did you get a sense from him how much, in fact, he had been using to treat the symptoms?

A. That would vary quite a bit. You know, there would be some days, particularly with pain or stress and anxiety, that he'd take a little more or less. If I didn't make a note that he was on specific doses ... But, I mean, any one person could be on two or three one day and five or six the next day. That would be, you know, a typical story.

Q. Do you recall whether or not you got a sense from him how much cannabis he had been consuming per day at that point?

A. No, I didn't make a note of it.

Q. No?

A. Yeah.

Q. Below it it says "Method of medical administration".

A. Yeah.

Q. There's smoked, vaporized, and eat. You have a note next to eat; what's that?

A. "Not yet." So he's vaporizing most things, in other words.

Q. So how's vaporizing different from smoking?

A. It's cooler; there's no smell to speak of for the public's point of view; it's the same dynamics - rapid onset, duration three hours - but too high a dose. At this point we were, you know, in the process of trying to get doses down lower because of the eating, but this is, we're seeing, you know, a point in evolution to that place. It hadn't happened yet so ...

Q. So he had been vaporizing?

A. He was vaporizing, I'd say.

Q. Did vaporizing, does that carry with it the same type of concerns you indicated earlier with the variability in dose and the uncertainty in dose as smoking?

A. Yes.

Q. And then under "Strains", it looks to be four different things listed here. What are they, first, starting

with the first one.

A. Midnight, and Midnight is a hybrid one-to-one, 10 percent THC and 10 percent CBD. So it is the CBD that we want to see every day. It's typically a daytime use - where it's got a slight sativa dominance it gives you energy; at the same time, CBD is there for safety. Elevare is pure sativa, THC only. The ...

Q. So you said ... Sorry to cut you off, but Elevare, how do you spell that?

A. E-L-A-V-E-R-E, I think.

Q. So Elevare, and what was that one?

A. Pure sativa, THC only. That would be a favourite of people. If they felt anxious during the day they'd take a quick little puff - it'd be a vaporizer in this case - to take the edge off an anxiety. It was very good for anxiety.

Q. And he was taking that in the day?

A. Yes.

Q. And below that one, the next strain?

A. The next two are indicas, Remissio (sp?) and Sedamen, so the note to the right is "Eve. and bedtime". Indicas are the bedtime, relax, good for pain, THC only again.

Q. So what's this first indica, what's the name of this

one?

A. Remissio.

Q. Remissio?

A. Yeah.

Q. And the second one was?

A. Sedamen. S-E-D-A-M-I-N (sic).

Q. So you were aware that he was taking those four different strains during the period of time?

A. Yeah.

Q. And did he indicate how he was fairing out with those four different strains?

A. Well, the symptom listing is next.

Q. Okay.

A. Yeah.

Q. So would these four strains, was he consuming one at a time or was he mixing them together or how was that being consumed? Was he mixing all four into ...

A. No, no. These are one at a time type things, yeah.

Q. And then we have a reference below that to "alcohol" is circled, and you said two beer a week is what he reported?

A. Right.

Q. Did you have any other concerns with respect to

whether combining alcohol with cannabis was maybe an issue?

A. Not at two beer a week.

Q. If you'd turn to page 5, so you have some discussion with him, follow-up with respect to pain. You indicated earlier his back, he had indicated he had some complaints.

A. Yes.

Q. What was the discussion about and what was the result?

A. Well, I'd want to know how effective it was for the pain.

Q. And did he indicate whether or not it was?

A. If you keep going, I'll tell you the answer.

Q. Sure. We'll just scroll down.

A. Yes, so what this means is, he was saying the average is six to seven, and that would be before the marijuana, and then down to an average of two.

Q. And we see circled "LBD", what's that?

A. Just low back pain.

Q. All right.

A. That's my bad writing, that's all.

Q. Sure. We turn to page 6. So again we see this PTSD-related questionnaire. So I understand that you would have ...

Here it indicates Before Treatment and After Medical Marijuana?

A. Yes.

Q. So you would have gone through with him how he ranked his symptoms, 10 being the most severe, zero being the lowest.

A. Yeah. And this is all my writing.

Q. Okay. So you did the scoring here?

(13:56:02)

A. I did. So I would have asked him about each one of these, you know, before and after type thing.

Q. So how did he indicate ... Was there any discussion about his anxiety before versus after?

A. Well, just it's an eight before the marijuana and a four afterwards, and again those are kind of rough averages that people give you, so very subjective.

Q. Hypervigilance?

A. The same idea, from 10 down to nine, so it didn't change much. He remained pretty hypervigilant is what that means.

Q. And did you discuss wit him what hypervigilance was?

A. Oh, yes.

Q. Yes.

A. When you're at the grocery store are you checking

everything or do you sit with the back to the wall at the restaurant or do you even go in public perhaps. You know, there's ... A nine out of 10, it depends on what he's doing socially. A lot of people avoid all social contact. Now he was social, he was in public. It was just that he was watching still, he was checking everything to make sure it was safe, looking for IEDs or, you know, dangerous people, or checking things out, whether they deserved it or not.

Q. And did he, do you recall if he described that to you?

A. That's what that would mean. Like I say, we're talking many years ago. I don't remember much of the conversations here. No.

Q. Okay. And depression went from ...

A. From 10 down to a six to seven.

Q. Anger and irritability?

A. That was ... it would have dropped down to a three from a 10.

Q. And suicidal thoughts?

A. From five down to one.

Q. Did you ever review with him what his suicidal thoughts might have been, do you recall?

A. Besides suicide, you mean?

Q. In terms of did he ever discuss suicide by a certain method or get into any details about what specifically he was thinking?

A. Suicide thoughts don't mean a plan. It's just the thought of I don't want to be here anymore is the typical thing. I would go on to ask them, When you're suicidal, what is it that stopped you from doing that at that time? That's always the question I would ask at this point. And that analysis would come out at that point.

Q. I notice you have an indication on the left "off all meds" and you've got an eight to nine indicated and a sort of a squiggly line that seems to consume every one of these ...

A. Yeah, it's just an average on this side. Sometimes I'll put an average on before and an average on the after.

Q. Okay. I notice that there's nothing filled out in terms of avoidance of triggers, flashbacks, intrusive memories, nightmares, distorted sense of blame - there's a number of things that aren't filled out.

A. Yeah.

Q. Sort of the before and afters. Is there a reason for that?

A. Yeah. The key issues of what we talked about ...

Now, again, I don't want to get into flashbacks until I know them better at a ... You know, when I have met a guy six or seven times, we can talk about trauma and things like that. At this point it's just we're avoiding those things because of the flashback, I'm trying to avoid that during an interview at this point.

Q. But something, for example, poor concentration, there's no before, no after filled out.

A. Yeah. It's not as important as the ones we talked about, so really we're just being efficient with time, I think.

Q. So sort of the reason why some aren't filled out was more to do with time management as opposed to significance or ...

A. Well, time and ... The ones we've talked about, in my mind, are the more important issues. I mean, poor concentration and easily startled is not that important for me at this point.

Q. Okay.

A. So ...

Q. But they are symptoms, would you say, of PTSD?

A. Absolutely. Yeah.

Q. If they were symptoms and you're trying to evaluate the success of the therapy by cannabis, would there be a reason

why you wouldn't note them?

A. I'm not trying to establish a diagnosis here anymore. I already have that established. I'm looking at the key issues that define how severe is PTSD. So it's not confirmed that he has PTSD anymore. I'm just trying to hit the key points that would indicate to me if this was effective or not.

Q. Okay. Next, page seven. There's a whole section of "Response to Treatments", but there doesn't appear to be any notes made. Is there a reason why? Did you go over that with him?

A. It doesn't appear I got too focused on that at this point.

Q. Do you recall if there was ever any discussion with him in October about response to various treatments or ...

A. We kind of touched on that the first time around, if you remember there.

Q. Yes.

A. And until people are stable enough, in my own mind, we don't really push them into therapy. Like, for instance, psychotherapy is not for someone who can't sleep and has a lot of pain still or, you know, the anger and irritability is too high. They can't handle that kind of relationship yet.

Q. So ... but did you ask him if he was, at this point in October, seeking any other therapy and how he was doing with that? Do you remember?

A. I didn't make any notes, so I can't remember. Yeah.

Q. Page eight. There's a whole section here where it says "Social/Family Impact". And it says, "Please briefly describe the impact your PTSD symptoms triggers and accompanying concerns that have affected you and your family." And there's nothing filled out.

A. That was filled out on the first one, if you understand because that's not going to change too much from ... that section is more designed to find out how much has PTSD affected your life. That won't change too much from one visit in three months, you know. In a year that will make a big difference, but we're only just touching on the basics at this point. So we've already established most of that thinking. Yes, it did affect, in most ways, all his ... all those aspects.

Q. Is this a spot where if anything had changed, the impact, you would have noted it? Anything changed between first visit and second visit?

A. I wouldn't even expect too much change in those things yet. And so I really don't focus on this part on visit two.

Q. And, again, we have a whole section of sort of before treatment and after medical marijuana. It talks about relationships with brother, sister, parents, your belief that you're valuable. Is there a reason why the before and after wasn't completed here on this visit?

A. It was done in visit one. That's why I don't do it in section two ... or visit two, I mean.

Q. So I guess back to if you're trying to get a baseline and an assessment as to whether or not cannabis treatment is working ...

A. Yeah.

Q. ... is there a reason why you're not going over that exercise on the second visit?

A. Because my time is spent with symptoms. And his symptoms were satisfactory, from my point of view. This is very complex. Any one of those could take 10 or 15 minutes. I've only got an hour. I'm focused on symptoms. Yeah.

Q. And then under "Concerns with Medical Marijuana", you have a number of things written here. What do you have written?

A. Yeah. All that says is, "All positive with marijuana." "THC" represents marijuana, by the way. And that was a comment that it looks like his wife had made.

Q. And were you talking to Shanna Desmond at any point by October 1st?

A. No.

Q. Okay.

A. That was his report of her statement.

Q. So he reported to you that she saw positive change.

A. That's what that means. Yeah.

Q. Okay. And if we turn to the next page, page nine? And we have, "Alpha-Theta Training". Did he ever participate in that?

A. No. I didn't get that far.

Q. And what is "alpha-theta training"?

A. It's just neurofeedback. That's another name for it. Neurofeedback uses brain waves to see what part of the brain the integration is not happening correctly. Now with a guy with concussion, I was ... that would have been an important thing to move into once he's stable. Stable, in my mind, to go this direction, is they're sleeping well, they do better on ... if there's any changes in treatment such as medications, I tend to have them wait until later. So if they're weaning off of something, I wait until they're stable. They can be on medications but they have to be no changes recently and sleeping

well. That's the two big criteria for this.

Q. Okay.

A. Yeah.

Q. Did you ... a lot of this, certainly, would you agree, appears to be self-reporting on Desmond's part where he's ranking before and after.

(14:06:05)

A. Yeah.

Q. Is there any way for you to account for or did you consider sort of a placebo effect, whether he actually thought it was maybe working simply because he was prescribed it?

A. Placebo is part of treatment. It's a big deal. If he's doing well and if everything we do is placebo, bingo, I'm happy with that. But I think these numbers are more than a 30 percent you expect with a placebo so ...

Q. Okay. At the end of the October 1st visit, did he receive any prescriptions for cannabis?

A. Say that again?

Q. At the end of the October 1st visit ...

A. Yeah.

Q. ... did he receive any prescriptions for cannabis at that time?

A. I don't see them there. He was okay for another couple months and we were planning to see him back anyway. I think the plan was probably, after the next visit, to write it out again. So I don't think so.

Q. And do you know if there was a scheduled follow-up visit set by you at that point in time?

A. No. We would have had another visit, you know, in the works. So we see them every two or three months until we're happy with the way things are going and then we can write it out for longer periods after that.

Q. So if we look to page three, at the top right-hand margin we see "February 23rd, 2016" ...

A. Yeah.

Q. ... sketched out by you on the October 1st chart.

A. Yes.

Q. What was that representing?

A. It's just a follow-up. So in the effort to reduce the amount of paper we're dealing with and time, if things are already in place, I don't, you know, duplicate things.

Q. So that is scheduled ... that would have been a scheduled appointment ...

A. Yes. Yeah.

Q. ... after the October ...

A. And I assume that appointment would have been designed for, you know, Are we going to write this out again for you or not? If you don't like it, that's fine. If you do, that's fine. We'll proceed. But I would have scheduled that probably in October.

Q. If we could turn to page 17? So, Doctor, you indicated that Shanna Desmond had been listed as one of Lionel Desmond's witnesses in the treatment. And one of her obligations was going to be to disclose to you ... report back to you, I guess, any concerns or issues.

A. Yeah.

Q. If we could scroll down. When is the first time you hear from Shanna Desmond, Lionel Desmond's wife?

A. Well, it looks like November 16th or 17th.

Q. And there's a note here. And this is written on his July 2nd, 2015 chart.

A. Yeah. So I ... you know, I'll use those pages to write notes on things like that.

Q. So I don't mean to be overly laborious, but because it's in your writing, and I can't make it all out ...

A. Yeah.

Q. ... could you read into the record what your note is from November 16th/17th?

A. That whole thing, you mean?

Q. Yes, if you don't mind.

A. "Phone call from Shanna, November 16th or ... (she might have phoned twice and probably I didn't get the first one or ... you know, that's what that kind of means) stating he is angry and aggressive." Manic was the word that was used. She's ... and so when I talked to her, she said she's not aware of any medications or strain changes. "Call on the 17th." "Call on the 17th." He's off medication still. Oh, so I was trying to establish whether he had been put back on medications. Knowing that they had had adverse reactions in the past, I was concerned. Sometimes when you go on a medication, things go really bad, including suicidal thinking, manic feelings, more depression and everything. So that was my concern had he been put back on medications or had he come off medications such as the marijuana, for instance, or things like that.

Q. And what did you have noted?

A. Off ... well he's still off medication.

Q. Okay.

A. He's no better, according to our records. Oh, "Much

better (sorry) according to our records."

Q. So, again, that's a note ...

A. Yeah. Sorry. I would have had this discussion with her. I was asking her, you know, Has there been anything new? New pills, any difference in strains? Sometimes you get into a wrong strain and things go bad. You need to avoid that one from now on, that type of thing. That's part of the experimental trial part. So she wasn't aware that anything had changed. So that's what that means. And then the next part is a call to him and he says,

> Strains are stable with no change. No excessive doses or inappropriate strains or other medications and no return to pharmaceuticals. No signs of anger or mania. (This is his report.) He disclosed her recent money issues and manipulation of events and fraud. Used his license to sign contract with telephone company. He was en route to Nova Scotia to sort out legal issues ... sort legal issues out. Felt his marriage was in jeopardy.

So that's his report to me on the phone when I finally get

a hold of him so ...

Q. So do you know if you speak to him immediately after you speak to her on the 16th or 17th?

A. I think I tried a few times. I think there's some notes there somewhere that say I tried ... I think ... I didn't get him until December. It was probably like a week or two later, I believe.

Q. And I'm just going to turn to a page really quick to verify a note that you had made. If we turn to page ten, this is on Lionel Desmond's July 2nd, 2015 chart. The top right-hand corner there's a note. Do you see that? It's ...

A. Yeah.

Q. ... something one to three. What's that?

A. "December 1st and 3rd."

Q. Yes.

A. "Phoned several times in follow-up. Phone out of area." So I had been trying to catch him for a bit.

Q. Okay. So it's safe to say you didn't speak to him until some point after December 3rd?

A. Yeah. I think so.

Q. If we could turn back to page 17. So I'm going to ask you some details about this particular call. So Shanna Desmond

phoned you. Do you recall roughly how long that conversation was?

A. No. It was probably pretty short, I assume. I just ... I was asking her, What's going on? And I thanked her for phoning, probably, because she's a witness and she has the right to speak to me about this. And, you know, wouldn't have been more than just a few minutes, probably.

Q. Does she ... did she sound concerned to you, on the phone, for Lionel Desmond?

A. She told me what she said. She was ... you know, she had that much concern. I don't ... she didn't seem upset or anything. I just said, Well, what's going on? And she would have said, well, he had had this day when he felt, you know, there was anger and ... the word "manic" came up so ...

Q. And I notice you have the word manic in quotes. So is that a term that she used?

A. That's a term she used. Yeah.

Q. What did she say about manic? Did she say what he was doing specifically that would be manic?

A. That was her term. Now she's a nurse so ... it's not a diagnosis by any means. It's simply probably he was hyper or, you know, a little aggressive, maybe. I'm not sure. You know,

manic could mean a lot of things to a lot of people.

Q. And you noted anger and aggressive in her description of Lionel Desmond.

A. Yeah.

Q. Did you get into the details of what it was, how was he showing his anger, or what types of aggression he was showing?

A. I don't recall that. No.

Q. No?

A. No.

Q. Do you recall if she indicated any concerns with respect to her safety or ...

A. No. I don't remember anything like that.

Q. Do you recall if she had said who he was angry and aggressive with?

A. I assume it was with her, so ... where he was ... he could have been just angry in general and just blowing off steam, too. I don't know.

Q. So how did this phone call end with Shanna Desmond? What was the plan, if there was any plan?

A. The plan was simply to ... thanks for letting me know that things are going this way. I'll be in touch with him as

soon as I can. Because that's how ... that's what this process is all about so ...

Q. Do you recall if there was any discussion with her as to whether or not he should maybe go to a hospital or come back in to see you? Anything like that?

(14:15:58)

A. I mean if I didn't make a note of it, it ... she ... I think she was just notifying me of the fact that he was in this state and she wanted me to be aware of that. And she would have been aware that she was able to alert me to that issue.

Q. Did she, at any point, indicate to you ... discuss whether or not there had been any interactions with the RCMP in November at the time of this call?

A. She didn't mention that. I don't think so.

Q. And so you speak to him at some point after December 3rd and you noted a number of things and comments he made to you. Is it fair to say that he's describing a number of things that you read into the record, that he seems pretty stressed at that point?

A. The only thing he was stressed out about was the money from what I gather. When I asked him, you know ... or, you know, I would have said to him, Listen, I had a call from your

wife. What's going on? And I said, Have you changed anything? Have you done anything that may have triggered things off? And, basically, he was more focused on the money aspect. He was upset about that. I remember him being angry and he was ... he felt he had been used, I think. That was the ... so he was heading back there to sort things out from what I ... yeah.

Q. And when you say "heading back there", reference to Nova Scotia?

A. Yes. He was ... I think I caught him en route. He was driving, it sounded like. He was en route to Nova Scotia to sort legal issues out. He lived in New Brunswick still.

Q. Yes.

A. So ... yeah.

Q. And this whole concept of he discloses fraud, what was that all about?

A. Well, I don't know any more than what I wrote. Basically, I think he thought that she had signed his name to something to probably get some telephone contracts. That's what I gathered. So I mean the validity of that, I wouldn't have any idea so ...

Q. But it's something he starts, I guess, unloading onto you, telling you.

A. That's what his focus was. You know, he was angry at that issue so ...

Q. And it indicates, "Felt his marriage was in jeopardy"?

A. Yes.

Q. Did he elaborate further on that?

A. I don't recall any more than that.

Q. So if you were to say ... the impression you got from both phone calls, would you say that this is a relationship that's going well?

A. No. They've got money problems and he's pissed off at however it's being handled. And, you know, you think, Well, the angry and aggressive manic thing probably was related to money somehow. That's probably all I could conclude from that.

Q. And you used the phrase he was "pissed off."

A. Yes.

Q. Is that the impression you got from him during your conversation with him?

A. Yes.

Q. So it wasn't something that he was sort of calmly relaying this to you as a matter of fact, This is what's happening. He's ...

A. Yeah.

Q. ... upset about it?

A. He was upset. Yeah. I didn't ... you know, I didn't sense that what she ... I didn't ... I was there trying to check the word "manic".

Q. Yes.

A. Are you manic? That would have come up for sure. And, you know, Are you these things that she's saying? And the answer would have been, you know, he was angry ... I said, "No signs of anger or mania. He's just upset about money."

Q. So, Doctor ... and I realize that you're one person in a large group of professionals. But armed with this sort of information at this time, did you get a sense of whether or not it's hard to separate PTSD symptoms, in the classic sense, from marital and life and financial stressors, that they kind of go hand-in-hand with each other?

A. Marriage stress is going to aggravate all these things for sure. Yeah.

Q. And did you come up with sort of any concept or any sort of plan as to maybe how this can be collectively navigated through in Lionel Desmond's best interest?

A. I didn't think their money affairs were any of my business. You know ... and I'm sure the word "marriage

counseling" has probably come up a few times, you know, with him. He just thought it was a marital ... or a money issue. Yes, they had had marriage issues even as ... back as far as Dr. Joshi's report in 2011. He said they've been having marital problems and money issues back ... that far back. So this is not a new issue. It's a raw issue, though, for sure. He's pissed off and he's been that way for years, so ...

Q. And did you discuss the idea of maybe ... clearly, you couldn't do it and wouldn't do it, but this concept of maybe get in to see a marriage counsellor or a therapist of some sort? As part of your treatment, did you talk about that to him?

A. That would have probably come up. Yeah. But, I mean, do marriage counselors deal with money issues? You know, that ... I mean there's issues between communication and, you know ... with a spouse and so on and then there's money issues. You know, I mean you can go see your banker maybe and they can solve that one. I don't know. It's not clear from this event, you know, what is the most important issue. Does he need a loan from the Bank of Nova Scotia or does he need an actual marriage counselor? I'm not sure.

Q. And fair enough. At this point, are you aware whether or not he has a case manager from Veterans Affairs in November

...

A. I don't remember that.

Q. ... December?

A. But, yes, I would assume. The case manager would have been there in June of '15 and should have had developed a relationship by this time. And I was ... I should be probably involved, you know, as well, so ...

Q. Did you get any sense that there was another professional outside of you that were ... was available to him or discussed with him how to navigate through those other sort of side issues ... stressors, I guess, of finances, marriage, anger?

A. Well, I mean I knew as of the February visit that he was going to see Bellwood, Ste. Anne's, and that another physician had seen him. OSI, I assume, had arranged that ... you know, that he have some extra therapy and so on at that point. So I, yeah, was aware indirectly. I would say I don't remember direct details like that.

Q. And if we could turn to page 18? So when you first learn about Bellwood ... and what was Bellwood? What was your understanding?

A. What is Bellwood?

Q. Yeah. Your understanding of what that was.

A. Oh, yeah. We've had many people go through Bellwood. They have an excellent reputation. It's a great opportunity to get someone in for therapy in many ways. You know, it could be addiction, it could be PTSD, could be alcohol, could be a bunch of stuff. And they have a good reputation. I was happy to hear that he was getting some extra attention that way. And anyone with PTSD would jump at the opportunity to attend that service.

Q. When do you first learn about ... that he may be attending Bellwood? When do you first ...

A. On the February visit.

Q. So it's not until February 23rd that you find out about it.

A. Yeah.

Q. And you said you had some knowledge of what Bellwood was. So I understand that was going to be an in-house sort of residential treatment?

A. Yeah. So it typically could be a one- or up to three month-visit; you know, a comprehensive program, in-house for sure. And he seemed to be looking forward to it. And they had told me he had to come off his marijuana to be admitted which was standard protocol.

Q. And that was going to ... Bellwood is in Quebec?

A. Yes.

Q. Did you get any indication from him as to when that was going to start ... that program?

A. He said in about two weeks. I think I made a note of that somewhere.

Q. Okay.

A. Yeah.

Q. So how did he seem about the opportunity to go to Bellwood and get involved in this residential treatment program?

A. He seemed progressive. You know, he was looking forward to it. He said, I'm off the marijuana. I'm going to Bellwood. I said, Great. Are you ... you know, you're looking forward to that? And he said, Well, they've taken me off the marijuana. It's the only downside. But he seemed positive about that.

Q. Did he seem open to the idea of sort of engaging that service and putting in an effort?

A. Yeah. Pretty sure. Yeah.

(14:25:57)

Q. So did you get a sense of when he stopped cannabis?

A. He had been off it at the time I saw him, so I ... and

they had to have him off it for two weeks or so, two ... so he was off it already before I saw him. Probably, you know, by a few days, I would guess. Yeah.

Q. And did you ... having some knowledge ... and I realize that you don't know all the details of the program. But, at this point, you had met with Lionel Desmond on two occasions and then the third being February 23rd.

A. Yeah.

Q. You knew a little bit about him and his circumstance. Did you think Bellwood was probably going to be a good sort of course or direction of treatment at that point for Lionel Desmond?

A. I would ... I thought it was an excellent next step. And I knew that, you know, I was ... I probably had pushed the button because that's what case workers and OSI are good ... you know, they're up for stuff like that. So I thought it was a natural course of events.

Q. So after February 23rd or at February 23rd, had you written Lionel Desmond any medical prescriptions for medical marijuana?

A. No.

Q. So, generally, this February 23rd visit appears to

have been scheduled, as you indicated, back in October.

A. Yeah.

Q. What was the, I guess, initial intended purpose of the visit?

A. Just a general check-up, you know? I assume the intention was ... in October was to write him the prescription, but he was going to Bellwood where they were taking him off it. And I said, Good. Okay. Well, just ... let's just see how that all pans out. Because Bellwood would be anti-marijuana at that point. I don't think they are as much anymore. And they would probably put him back on some pills. That was probably the only concern, although I ... you know, I don't know what happened there. I didn't get any communication after he went so ...

Q. Did you have any conversation with him during this visit about the November occurrences and your conversation with him in December where he says he's heading back to Nova Scotia? Did you get into any discussion with him as to, How are you doing? How did that go?

A. Oh, yeah. I asked him ... well, the ... you know, he brought this form in for the gun license. And I said, What's that all about? And ... is that what you're asking me?

Q. Well, in general. I'm trying to get a sense of the

conversation and how it went with him that day.

A. On the day I saw him or ...

Q. Yeah. February 23rd.

A. ... is that ... he was ... what would I say? I guess he was embarrassed by this, the event on ... the RCMP had come. He said he overreacted to it and he said some things that, you know, he didn't really intend, and that he was looking forward to the Bellwood thing. Does that answer your question?

Q. I guess. So to sort of direct it ... so page 18 in front of you ...

A. Yeah.

Q. ... it's a Medical Assessment by Physician form. You're well familiar with that particular document.

A. Mm-hmm.

Q. And that, I understood, came from the Department of Public Safety, Chief Firearms Office in New Brunswick?

A. Yes.

Q. And this was a form brought by Desmond to you on February 23rd?

A. Yeah.

Q. So were you expecting to receive this form on February 23rd?

A. No. It was kind of, By the way, can you sign this thing?

Q. And this form in ... at the top, it says, "Reason for Assessment". And it outlines the occurrence of November 27, 2015.

A. Yeah.

Q. And it outlines how police ... he had been threatening self-harm, the comments about suicide, and then ultimately being depressed. His wife had been concerned for his well-being. And he was taken to the hospital where he was seen by a doctor.

A. Right.

Q. So you would have read this part obviously, this form?

A. Oh yes.

Q. And so you have the conversation you indicate with him regarding that particular occurrence?

A. Correct.

Q. And you say he kind of felt embarrassed over it?

A. Yes, he said it was a bad day and I said a bunch of stuff that I didn't mean. And he talked about what happened that day and he saw another doctor at the emergency room, I believe, and they said he was fine, the RCMP said he was fine. And I said, Well, what's that all about? He said he was angry

and said a bunch of things, you know, overreacted to whatever the stresses were that day so ...

Q. And when you're talking about this, is there also a conversation about what happened earlier in November when Shanna Desmond had called you and told you he's angry, aggressive, and manic?

A. It always came back to he was upset about money and things like that. It was never that, you know, any other reasons were behind his anger. It wasn't that he was that way all the time. He gets really upset when the money thing comes up and he overreacts to it. And I assume that's what this kind of stuff was all about as well.

Q. So on this date when he presents you with this form, you're given a description, a brief description of the November 27th RCMP incident. Does Lionel Desmond or anyone ever tell you that there was an occurrence in Nova Scotia before this on November 18th, 2015?

A. I didn't appreciate that, no. I thought this was the event that everybody was talking about.

Q. So on this date, February 23rd, when you're asked for your position on this firearms, whether he should possess them or not ...

A. Yeah.

Q. ... you have no knowledge from either Lionel Desmond or Firearms that there was an occurrence in Nova Scotia where the RCMP got involved on November 18th?

A. This event I thought was the only event that had occurred, so yeah.

Q. Okay. And so if I indicated to you that there was an RCMP occurrence in Nova Scotia as well the day after November 27th on November 28th the RCMP in Nova Scotia attended Lionel Desmond's residence where he was seeking to retrieve his firearm, other marital property, and yelling at Shanna Desmond's father's house, were you aware of any of that?

A. No.

Q. So from your perspective, other than what you had reported from Shanna Desmond about November and this particular November 27th occurrence, that was the extent of the information you had about Lionel Desmond and his circumstances in November?

A. Can you ...

Q. I guess, yeah, I'll rephrase it. So this November 27th description ...

A. Mm-hmm.

Q. ... and what Shanna Desmond had told you on the phone

...

A. Yes.

Q. ... about an incident where he was manic, that was the full extent of your knowledge of occurrences in November?

A. Correct.

Q. Do you think it would have been helpful to you prior to completing this form, and we're going to get into the details of it, to have known maybe those other occurrences and the details of those?

A. Of course.

Q. And why would that be?

A. It would have given a slightly different picture, so yeah.

Q. Would you have perhaps, had you known about other occurrences, would you have naturally asked Lionel Desmond about them?

A. Absolutely, yeah.

Q. So this particular form, he presents it to you, you understand ... did you understand the purpose of ... behind the form, what it was requesting you to do?

A. They're asking for my opinion as to the FIP to his application.

Q. Do you ever have any discussion with Lionel Desmond on February 23rd about his chances of ultimately getting his firearms back?

A. Yeah, I said, Listen they're well aware of things in the background here I highly doubt you're going to get this application. My opinion in your ... in terms of your stability is the way it was. I'm only a, you know, a link in the chain of decision-making here. I didn't ... I told him I didn't think that his chances were great to get his application completed in a good way.

Q. So you said you understood you were a link in the chain of the decision-making?

A. Correct.

Q. What do you mean by that?

(14:35:54)

A. Well, I knew there were several steps to the decision to give him the license and that this opinion was only one part of that whole process, and that the RCMP were obviously well aware of other issues. They would have made their own evaluation of what happened that day. So the ... I said I'm not the one to make the final decision here, I'm just a step in the final decision to be made here.

Q. So at any point did you sort of think that I'm the doctor, I'm answering the ultimate question as to whether or not there are any concerns or whether or not he's fit to possess firearms, that you or I am the one that makes the decision and final decision as to whether he gets his license back or not?

A. I didn't think I was the final decision-maker here. I'm simply someone they're asking my opinion on as to his stability in terms of harm to himself or others, which I had never ... I had never seen evidence of.

Q. Were you ever contacted by the New Brunswick Chief Firearms Office or any Firearms office from New Brunswick?

A. No.

Q. Were you ever contacted by any Firearms office in Nova Scotia?

A. No.

Q. So ultimately we have checked off on the form, I'm assuming it was you that checked off "No, I have no concerns that the applicant named above may pose a safety risk to himself, herself or others"?

A. Right.

Q. And then what's the note in "Comments" below?

A. "Non-suicidal, stable, no concerns for firearm usage

and appropriate license."

Q. So when you're evaluating and making the assessment that he does not pose a safety risk to himself or others, and non-suicidal and stable, no concerns, are you talking about on the date of February 23rd or ... and I realize you don't have a crystal ball, but when you're making that comment and checking off "no", are you evaluating him in the here and now as of February 23rd?

A. The opinion would have been based on what I knew of Lionel through any interaction I had had with him. I'd never seen any ... or we talked about the suicide and so on, you know, I had not ... did not think he was suicidal nor ... and homicide didn't even come up. You know, what I knew of Lionel to be was anything but someone in ... unstable or unsafe to himself or others, so that was my opinion. And it was ... you know, whether it was based on just that one day or the other events where I had a chance to meet him and so on.

Q. Had you filled out these type of forms in the past?

A. Yes.

Q. Have you, at times, filled them out in the positive that yes, there were concerns?

A. Yes, and have since.

Q. And have since?

A. Yeah.

Q. How did you ... and I know it's hard to sort of get a full sense. Had you known about the other occurrences, November 28th going back to Nova Scotia looking for his firearm, yelling at his father-in-law's house; the week before, November 27, RCMP responding, he's manic according to his wife. Had you known those occurrences is it possible that you might have assessed whether or not he was a risk to himself or others a little differently?

A. It's possible and, yeah, you know, I probably would have wanted to speak to, you know, the adjudicator here and, you know, find out more about what's going on maybe.

Q. In your experience, Doctor, in seeing patients and many, many military veterans and members of the military, have you ever received a call from the Firearms office?

A. I can't ever remember having conversations with them. Now the ... I mean, I go on to say the new forms that they've developed are wonderful. They ask questions that should be asked that were not asked here. I guess in retrospect it's like a "yes" and "no" is not quite maybe what we should be passing on. If there's other information for them to consider, which is

what the new form is designed to do, it collects all kinds of information that could be weighed by someone who is checking out all the sources and making the ultimate decision on "yes" or "no".

Q. So ultimately when you're asked on the old forms of yes/no and sort of that's it, bottom line yes/no and comments ...

A. Yeah.

Q. ... currently you're of the view that perhaps that may be a little restrictive?

A. A yes and no is very restrictive, yes.

Q. Yeah. In what way?

A. If, for instance, someone is presenting a request like this and there's other evidence that could be weighed, I don't know all sources of information so an opinion ... all I can do is give evidence of information that could be useful. And I guess if I ramble on about things that have happened in the last year or so they can check out some of those sources and decide ultimately if that's important or not. The newer form, I'm sure you've seen it, is much more comprehensive and so on, yeah.

Q. And that's something you see as an improvement?

A. Big time.

Q. Do you think ... since the new forms, do you recall roughly when they came out?

A. I saw one about I think two months ago, that's the first time I saw it.

Q. Have you noticed any sort of change as to whether or not the Firearms office ... actually, the investigator reaches out to you and speaks with you directly for your comments? And I appreciate you're very busy but ...

A. Yeah, I would welcome that. With the newer forms they may not have to as much because they're getting, you know, other pieces of information that they might weigh, you know, more heavily one way or the other and so on. So this form, yes and no, I almost expected to ... for him to be turned down, and I almost was hoping that I would have a conversation with someone, though ... anyway, it's improved that's all I can say that way.

Q. And so ultimately, Doctor, that particular day February 23rd when you checked off "no" to concerns about risk to safety to self and others and you made the note of "non-suicidal, stable, no concerns for firearms usage and appropriate license", are you able to generally say what did you consider when you reached that conclusion and indicated that?

What were the things that went in to your consideration to

formulate that view?

A. That's a complex answer but, you know, he was very upfront with his feelings; he wasn't an alcohol or drug user; he was very open with his feelings; and he had things to live for. He had a group of friends. He loved his daughter at least and ... anyway, I didn't see any of the instability. His suicidal thinking had dropped dramatically and my analysis of stable and unstable is based on those kinds of pieces of information.

Q. In terms of the visit itself February 23rd, this appears to be the only document in the file referencing that visit. Is there a particular reason why there were no other charts or reports?

A. What kind of ...

Q. I guess in ... we saw the visit of July 2nd, there was an amount of paperwork there with various notes on it, October 1st same thing, multiple pages, various notes, but February 23rd we just have a copy of this Firearms form that you were asked to fill out.

A. Yeah.

Q. Is there a reason why there was no other particular chart notes or reports for that visit?

A. I think this became the focus of our discussion, plus

he was off marijuana and I was kind of out of the picture at that point because he's no longer, you know, using it and potentially probably ... well, I didn't know if he was going to be using it again. If he was, we would have made much more notes.

I asked him why he wanted a firearm license and he was a hunter and enjoyed that aspect and I knew he was a lover of Mother Nature and so on. So, you know, I think it spent ... or I spent most of time discussing this topic here and that the marijuana was kind of out of the picture at this point.

(14:46:01)

Q. So naturally when you were asked to provide your opinion and sort of sign off this form one way or another, you had spoken to Lionel Desmond on July 2nd, October 1st, some point in December ...

A. Yes.

Q. ... so you would have only spoken to him on three prior occasions?

A. We ... no, we had seen him socially at our events ...

Q. Okay.

A. ... and he had shown up a few times, I can't remember exactly how many. But he was gregarious. He had lots of

friends, they'd come and go at our place with the open house concept that we had. So, again, that was part of knowing that he was socially connected, lots of friends. And I guess in retrospect, I mean, everyone says he was the last one that they would have thought that would have go on to ... you know, to this kind of an event.

We all thought that way, you know. He was very ... he had a sense of humour and, you know, enjoyed his friends and he had quite a social network in New Brunswick at least, I don't know about Nova Scotia, but he was connected.

Q. And I'm not trying to by any means diminish your qualifications and expertise, but is it fair to say that when you're completing a form such as this and assessing suicide risk, assessing mental stability, concerns of firearm usage or possession, that's a very psychologically focused?

A. Yes.

Q. It's very mental health related?

A. (No audible response.)

Q. I just noted you nodded. I'm assuming "yes" ...

A. Yes.

Q. Is that right?

And I'm mindful of the fact that you're a doctor that has

significant more experience than most family practitioners or physicians with patients with mental health it's pretty significant, do you think that psychiatry or a report from a psychiatrist may be helpful in answering that type of decision rather than sort of unload it to the general practitioners?

A. I think a specialist in this field, now whether it's a psychiatrist or just someone trained to analyze this kind of thing. But, again, they'd come back to people like myself that knew him or others that knew him as well to collect the information so my attitude would still be uploaded to someone like that. And yes, it would be nice to have someone with a lot more expertise than a family doc that, you know, we're not specifically trained to analyze these things as well as a psychiatrist or someone equivalent to that.

Q. And I note as well that you had some knowledge that he was being treated and seen by Dr. Joshi for quite some time?

A. Yes.

Q. When you filled out this form, did you have knowledge of whether or not the Firearms Office was going to reach out to those other doctors to see what they thought as well?

A. Again, I thought I was only a single step in the chain so I assumed they were analyzing several sources to make that

decision. I didn't know ... or I didn't know if they were going to reach out to Joshi or not but ...

Q. Did you see any particular value in prior to completing that form and making that decision that you formulated to say, You know what, there seems to be a long medical history with Lionel Desmond that you were aware of in general ...

A. Yeah.

Q. ... that maybe I ought to sort of defer or look back into before providing that opinion?

A. I don't understand your question.

Q. I guess I'll break it down. So when you met with Lionel Desmond over that period of seven months ...

A. Yes.

Q. ... you knew that he had previous involvement with other mental health professionals such as a psychiatrist?

A. Right.

Q. And so prior to making the decision to sort of fill out the form and indicate your opinion, did it ever cross your mind that maybe I ought to look at those charts, those reports, to gather up more information about Desmond prior to reaching my conclusion?

A. I didn't think that was my job. My job was to give my opinion as to my interactions with Lionel. I thought the job ultimately was the adjudicator of Firearms to search as many sources as they felt to feel satisfied with "yes" or "no". And I knew I wasn't the only source by any means, there's RCMP, the doc at the emergency room he saw and other prior docs, and probably some other treating physicians, you know, such as OSI. Whoever sent him to Bellwood, I wasn't quite sure exactly who that was at that point, but I knew there was other docs involved. So I felt I was just an opinion that would be, yes, you know, weighed into the collection of information that would have surfaced as a result of that being looked at.

Q. Okay.

A. Yeah.

Q. If we could turn to page 25 of Exhibit 140. So, Doctor, this is page 2 of Dr. Joshi's September 28, 2011 report that you indicated was provided to you, you had reviewed with Mr. Desmond, you were familiar with.

A. Yeah.

Q. I'm just going to draw your attention in particular to sort of the end of the report where it says, "Occupational MELS". And the note indicates referring to Lionel Desmond and

his diagnosis of PTSD/major depressive disorder it says, "Unable to work in safety-sensitive positions, example, at heights, with hazardous equipment or with live weapons (it says) on ammunition."

So it specifically makes reference to "unable to work with live weapons". Did you review that with Lionel Desmond?

A. You'll notice up in the bracket above that it says "JPSU".

Q. Yes.

A. In order to go to JPSU you are signed off of active duty. This is a standard rubber stamp to say you don't drive their vehicles, you don't work with their guns anymore or do anything except receive therapy. So that's a standard. Everybody that goes to JPSU whether they have a sore back or PTSD would receive this rubber stamp to say that they're no longer serving. That's what JPSU is, is a process of out the door. So that's not meant to be a statement that he's any more than not serving. That's what that means.

Q. So you understood that section to mean in a strict sort of military serving context he shouldn't have firearms?

A. Right. Because Joshi had gone on in his statement he made it very clear he thought he was not suicidal and homicidal

in so many words.

Q. Mm-hmm.

A. And he had certainly given his opinion as to the fact that he was okay to have a firearms license and so on.

Q. What if you had other documents in Joshi's reports that said he was suicidal, he hadn't been coping well, had shown a number of significant symptoms of PTSD, could that have altered your view when you signed off?

A. It would have been weighed into my opinion, you know, if he had been actually suicidal. No one had ever said he was suicidal, including Lionel at different occasions. And I asked him that directly, there was ... you know, there was no qualms about it, that was not on his list of things to do. He was thinking only one out of a scale of ten now which is very minimal and I didn't think that was ... and he didn't certainly admit to any thinking along those lines.

Q. But had you seen reports that indicated that he was suicidal ...

A. At one point you mean?

Q. Yes. Would you have considered that prior to signing the form?

A. That would have weighed in to the factors, right.

Yeah.

Q. If we could turn to Exhibit 67, page 26. If we could scroll down. Okay, just leave it there for a second. If we could just have one second, Your Honour. If we can maybe turn to page 27.

(14:56:24)

So, Doctor, I realize that you don't have the benefit, and you may have never seen this report, basically, in December ... on December 2nd of 2015 or '16, Lionel Desmond is assessed by a doctor, a psychiatrist Ian Slayter at a clinic in Antigonish and Dr. Slayter did a fairly comprehensive assessment of Lionel Desmond and had Lionel Desmond sort of recount a number of things to him. Clearly this happens well after your involvement with Lionel Desmond to put it in perspective, and we know Lionel Desmond had been off medical cannabis for months prior to this assessment. But in particular where it says "Past psychiatric medications" and it indicates:

> He says he tried several antidepressants but cannot clearly remember which ones he tried. Fluoxetine and steraline or sterline (am I pronouncing) ...

A. Sertraline.

Q. ... sertraline may have been included. He does not recall any medications as helping. He was tried on medical ... he was tried on marijuana by medical permit and found it helped him sleep but made his thoughts of jealousy worse.

A. Right.

Q. Did Lionel Desmond report that sort of side effect or symptom to you during your time with him?

A. No.

Q. As well, if we could turn to page 26 and scroll down a little bit. Keep scrolling down. Okay, leave it there. Could you scroll down a little bit more. That's it.

So, in any event, Doctor, you would agree he appears to be indicating to Dr. Slayter that medical marijuana had not been working for him in some regard?

A. Made him more jealous it said ...

Q. Yeah.

A. Yeah.

Q. Did he indicate to you at all that medical marijuana ... other than being positive, did he indicate any negative effects of medical cannabis to you?

A. No.

MR. RUSSELL: I'm trying to find a passage, Your Honour, I had it, I apologize, and I had it flagged and I missed it.

So, Doctor, I'm going to draw your attention to, on the screen, the second paragraph. I again apologize, Your Honour, for not having this lined up a little more perfectly. The paragraph that starts with "His symptoms of PTSD ...", do you see that?

A. Yes.

Q. So I'm going to go down to midway through the paragraph and it starts with:

> He began to experience frequent nightmares of his wife cheating on him. He related the nightmares to the marijuana prescribed for the PTSD. During the day, when around his wife, particularly after nightmares of her cheating on him he becomes angry with her and believes that she might be cheating on him. At other times he is able to detach from those thoughts and realize that she is not cheating on him.

Q. So again he appears to indicate to Dr. Slayter that

he's equating some negative effects of being prescribed medical cannabis.

A. Yeah.

Q. Any time in your meetings with him, while you were prescribing the medical cannabis, did he report any of that information to you?

A. No.

Q. Did you get any suggestion from him whatsoever that that was a concern or that was the case?

A. The cheating part? No.

Q. Or that it was making his thoughts worse.

A. No.

Q. Had he reported that information to you, would you have taken sort of any steps to maybe change course?

A. Paranoia, as we talked about this morning, comes from too much THC. It lasts for three hours and it's potentially happening when you overuse marijuana. It should only last for three hours again. So if it's there more than three hours there's something else going on. There's either a real concern or there's a paranoid state, which probably is not related to marijuana. But there's no question that excessive marijuana can cause paranoid feelings and thoughts for three hours if it's

smoked or, you know, excessive doses at least.

Q. And I do want to make very clear that you had not seen him since February of 2015 ...

A. Yeah.

Q. ... or 2016. And he had not been under your care quite some time leading up to assessment.

A. Right. But does this mean he was on marihuana at this time?

Q. When he is reporting to Dr. Slayter he's reporting about his period of time where he was prescribed medical cannabis.

A. Okay.

Q. And that's what he's reporting.

A. Yeah.

Q. I'm just going to ask you a last series of questions. I guess if we can start with page 30 of Exhibit 140. Doctor, we have a number of pages, I guess, that go from 30 to 48 in Lionel Desmond's chart.

A. Right.

Q. Or records as applied to his treatment at your office.

A. Yeah.

Q. And this document was "Physicians and **Firearms Act**: A

Dilemma". Did you research this at the time you were treating Lionel Desmond?

A. No.

Q. And this document, you would agree, it talks about the physician's duty to report issues or concerns with respect to firearms.

A. Yes.

Q. And it does refer to filling out the exact forms that you had filled out on February 23rd.

A. Yeah.

Q. So how did this information come about? Who gave you this information or why were you seeking it?

A. Well after the event, you know, we had kind of gathered together to figure out what we knew of things and I had asked one of my counsellors, who is a vet who volunteers his time - he's done counseling courses and so on - to look at the information, to dig up as much information as he could so we could have a discussion about the whole topic.

So in preparation for that meeting, this is his research. He had presented these pieces of information and we had several counsellors and myself and I think some of the coaches were at that meeting just to try to make sense of what had gone on

ourselves. And this was just some of the information that he had dug up from the internet, I think.

Q. And if we look down at the bottom there's a series of handwritten notes throughout these pages to the end of the records, page 48.

A. Yeah. Right.

Q. And it said, "Firearms officer's responsibility". Is that your handwritten note?

A. No.

Q. Whose is that?

A. That's my counsellor.

Q. Trying to gather up some information as to ...

A. Yeah. Like I say, he was presenting as much information as he could to the group to, you know, form a discussion, bring up topics, and try to make sense of, you know, where this whole topic was.

Q. Like are you able to say where this particular document comes from?

A. I think he got it from the internet as far as I know. Yeah.

Q. What group is CMPA?

A. What is CMPA?

Q. Yeah.

A. Canadian Medical Protective Association.

Q. And is it possible that this is supposed to say to you this is sort of a directive or an outline from that?

A. Yeah, it seems that way, yeah.

Q. If we look up towards the top. And it says, "Cause for concern". And I'll just read in there. It says: "Thoughtful and prudent physicians should think carefully about providing such a letter. For example, due physicians have a duty to respond to such requests?"

(15:06:59)

This is referring to a similar type of a form that you had filled out on February 23rd?

A. Right.

Q. What is your understanding of your obligation as a physician to fill out that particular form for firearms?

THE COURT: I'm going to stop you just for a sec.

MR. RUSSELL: Sure.

THE COURT: So we have a document that comes from some place. Dr. Smith thinks it's coming from the internet, a counsellor dug it up for him and presented it to him and it winds up in the file. When you read the document it looks like

it may very well be from CMPA, some form of directive. When the doctor is being asked a question with regard to what's on the file the only way he can be asked that question is on the assumption that this is a directive that he would follow from CMPA. Otherwise he's being asked a question about something that just arrives at his office that may be from the internet and may not be from any kind of ... I'm going to call legitimate governing source or an advisory source for him, in which case I don't know how relevant it would be. So that's the observation I can make for a minute.

Mr. Hayne?

MR. HAYNE: Yes, thank you, Your Honour. My understanding is ... and I just looked on the internet myself, and this document appears to be a document that's available on the internet.

THE COURT: From what? Who makes it available?

MR. HAYNE: Well, this is me, but from my ...

THE COURT: Sure.

MR. HAYNE: ... investigation, it's from a CMPA website.

THE COURT: Okay.

MR. HAYNE: However, characterizing it as a directive, I think, is where I get uncomfortable. It's information that's

provided.

THE COURT: Advice. Well, when you put it out you're not putting it out to ... who are they putting it out to? We're having a theoretical discussion here.

MR. HAYNE: Sure.

THE COURT: I'm not going to ask you to speak for them directly but when CMPA puts that out they're putting it out to, what, advise, generally, doctors? Advise individuals who deal with doctors?

MR. HAYNE: I mean their website, if you look at it, has a number of pieces of information on medical/legal things, and whether it's information or advice or a directive, I think you'd have to ask someone from CMPA as to what their intent was.

THE COURT: Okay. Are there any disclaimers saying, There are doctors who might read this, don't necessarily follow this and we disavow whatever information might be in here?

MR. HAYNE: Well, I'm not personally, myself, aware of that. There is a disclaimer. Just looking at it now at the end:

> This information contained in this learning material is for general educational purposes only and is not intended to provide specific

professional medical or legal advice nor to constitute a 'standard of care' for Canadian healthcare professionals. The use of CMPA learning resources is subject to the foregoing, as well as CMPA term of use.

So it's information that's presented in this context.

THE COURT: Right.

MR. HAYNE: And I got a little concerned when the word "directive" was used, but I think with that disclaimer and this characterization, well, thank you for raising it and I like having the opportunity to present that aspect on the record.

THE COURT: Yeah. So we've had a discussion on the context of the question. So we have a document that I'm satisfied that it can be found on the CMPA website. It has a disclaimer. There's a disclaimer attached to it. So in that context, Mr. Russell is asking the question of Dr. Smith.

MR. RUSSELL: Yes, Your Honour, and I used the word ...

THE COURT: You might have to re-ask your question. It's been a long time since we heard it.

MR. RUSSELL: I used the word "directive" and I used it overly loosely.

THE COURT: Mmm.

MR. RUSSELL: Certainly, I did.

Doctor, I'm just trying to get your understanding as a physician of whether or not, are you on the understanding that you have an obligation to fill out these requests from firearms officers as a physician running a practice?

A. I assume if I'm asked I would give an opinion. I'm all for mandatory firearms reporting even. Someone who's found to be with a license that no longer should have one, it should be mandatory reporting. I don't think that's happening yet. I think for the safety of our society that mandatory reporting would be an important issue.

Q. And ...

A. And things change fast sometimes and I'm not sure if we have the ability to report that kind of thing. So if that answers your question. I'm all for disclosure of information for people for public safety. That would be my answer.

Q. And my second question is, when you get such a request to fill out that form and provide details do you sort of have a firm understanding of what your obligations are and limits of the details of information that you can share with the firearms office such as the whole history of your visits with your patient, et cetera?

A. I'm not clear on what the law would say about that. My own opinion would be that I would give as best disclosure as I could for public safety.

Q. So would you be able to provide a firm answer today if a firearms officer called you and said, Can we have access your charts, your reports, your background, your meeting? Whether or not you could disclosure that information in the context of filling out that form?

A. I would probably phone my College first and find out. So ... and I don't know the legal answer to that question.

Q. Okay. Finally, Doctor, in general, and I know we've asked you a lot of questions here today and in the meetings prior. Clearly, you became involved in this whole process and tragic set of circumstances. With your experience, could we get your sort of insight as to is there anything that could be sort of improved, changed, or recommended to make your job and your role a little easier? Kind of looking back in hindsight.

A. The communication thing has come up several times. I think information availability to whoever treats someone would be an item if you can get around the confidentiality issues and so on. I think there would be a lot of discussion about that in many directions. I think that in terms of improving programs

it's all about allowing people to develop relationships. If they've lost a major relationship I think any program has to, you know, enhance a new valuable relationship for the individual. Without relationships, they commit suicide. It's that simple.

So the relationships can be with many things. So if you're talking about improving DVA programs. You know, even the discharge programs are lacking tremendously. We've got other nations that do it correctly. They have less than one percent PTSD. They accept the trauma. They see these people as valuable. They embrace them and they say, We're okay, we've done the same thing, we know what you've done. Our PTSD soldiers are chastised. They're treated like lepers. We're cast to the wind, and really, it's all about pills and psychotherapy. It's pathetic. There's no developing of relationships, which makes the world happen. Without those, we need to redesign and rethink things.

And, you know, so there's lots of ideas along those lines. Is that kind of what you're looking at?

Q. And I guess would you have anything specific in mind as to how that could be sort of implemented, what sort of structure?

A. Well, it starts right back from, you know, when someone has PTSD in our military they don't want to talk about it. It goes on for years because they don't want to lose their job. It's okay to have PTSD. It happens to normal people. You know, if they're treated better when PTSD happens ... it's going to happen. It happens in every battle that ever happened in the beginning of time, but the response to that is, is it accepted or is it not accepted? You get kicked out of the military where you no longer belong to anybody and you're chastised and treated like a leper.

(15:15:48)

Or are you embraced and said, Thank you for your service, we love you and you're still part of our society, instead of being chastised to the point where you say, I don't even know if I belong to this society anymore, they don't like me anymore, they've kicked me out of the military, I've lost my job, I've lost my family. And there's no discourse for that. You know, it comes right back to that place.

Q. In terms of your experience with the number of veterans and military soldiers that you treat in your practice, do you see any concerns with respect to sort of that transition, that handoff from between the OSI clinics, ultimately, back to

the community and seeing doctors out in the community? Do you see any gaps there or concerns that you'd like to elaborate?

A. There's some major issues ... yeah, the communication is lacking, but a lot of it comes from lack of trust with OSI. The guys go to OSI for a while. They lose trust because it's part of that system that just kicked them out. They don't want anything to do with them. They're extremely angry. They often lose their ability to interact with OSI because they're talking about pills too much and psychotherapy too early in the process and they've been lost to their treatment programs.

So the lack of trust. There's a large percentage of guys that no longer want to deal with the system at all, and they're the ones that I see and that are probably the most volatile and dangerous people in the world, you know, in terms of risk to themselves. And, again, it comes back to the thinking of how do those programs embrace that soldier? You know, what are the attitudes? Oh, you've got PTSD, you're no longer part of our society for some reason. So ...

Q. Do you see any practical examples of how that handoff, I'm going to call it, can be improved upon? Like practical, concrete sort of examples where a veteran is in the OSI clinic. There may be a lack of trust. They're then sent back out to the

community and then they see you. Is there any sort of practical things that you can think of to make that transition easier that could be implemented?

A. That's so complex that I'm not sure I can give you a good answer to that one.

Q. That's fine.

A. Communication is what it's all about, and attitudes of how you handle people. Treat them with respect. The typical conversation with DVA is I'm on the phone for a half an hour listening to music and then when they do talk to you it's like they don't know anything about you and you're just a number. There's no warmness. There's no respect there to speak of. You lose trust very rapidly as a result of that process.

And that may just be a matter of lack of resources. There could be an attitude. Let's, you know, give these guys a hard time. They take it all very personal, of course, when it's probably just the system that's lacking the resources to actually respond appropriately.

Q. That would be all the questions for counsel, Your Honour.

THE COURT: All right. Thank you, Mr. Russell. In the normal course of events we would sit till 4:30 and there's seven

lawyers that might have questions for you. We won't get that done today. Hopefully you've made arrangements to come back for tomorrow?

A. If there's questions.

THE COURT: All right. I know that we had planned on doing something else this afternoon. I had told counsel that I was going to deal with an application for standing this afternoon as well. So I think that we started at 1:30. It's almost 3:30. I think we're going to break for the day today with Dr. Smith. Dr. Smith will be back here tomorrow morning for 9:30. Dr. Smith?

A. Are there questions for tomorrow?

THE COURT: There are. There are questions. I assume, Ms. Ward, you're going to have questions, are you?

MS. WARD: Yes.

THE COURT: Ms. Lunn?

MS. LUNN: I don't believe so, My Lord.

THE COURT: Perhaps not. Ms. Whitehead?

MS. WHITEHEAD: No, I don't think so.

THE COURT: Do you expect questions? No?

MR. MACDONALD: Yes, Your Honour.

THE COURT: Mr. Macdonald will have questions. Ms.

Miller is likely to have some questions.

MS. MILLER: Yes, Your Honour.

THE COURT: Mr. Rodgers is likely to have some questions?

MR. RODGERS: Yes, Your Honour.

THE COURT: Yes? And Mr. Hayne would have that opportunity to ask questions as well, apart from whatever follow-up and apart from whatever questions I might have as well. I might have a few.

So there will be some questions tomorrow. I'm hopeful you would be out of here by lunchtime, I guess. That's what we would shoot for. All right?

All right. Thank you. So we're going to adjourn the hearing for now and we'll be back here at 9:30 tomorrow morning and I had had a brief discussion with Dr. Smith earlier and he's aware of the fact that he's in the middle of his evidence and shouldn't discuss it with anyone. That would be a standard rule. You'll be aware of that standard rule. So you can talk about anything else you like but your evidence. All right. Thank you.

A. Yeah.

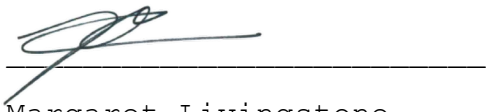
THE COURT: And those that are here for the application

for standing, we'll deal with that very shortly. All right? Thank you.

COURT CLOSED (15:22 HRS)

CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.



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February 28, 2020